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HEALTH *OR* TOBACCO

a report on the elimination of the
promotion of tobacco

MAY 1989

TOXIC SUBSTANCES BOARD
WELLINGTON, NEW ZEALAND

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HEALTH *OR* TOBACCO: THE ELIMINATION OF TOBACCO PROMOTION IN NEW ZEALAND

BRIEF SUMMARY

o Health effects of tobacco use

The medical and scientific evidence that tobacco smoking is the greatest preventable cause of disease and premature death in the developed world is now overwhelming. Tobacco contains over fifty toxic and cancer-causing chemicals. In New Zealand, over 4000 premature deaths per year are due to smoking. About 300,000 hospital bed-days per year are taken up by patients whose disease is attributed to smoking. Lung cancer death rates for Maori (men and women) are higher than for any other national population in the world.

o Tobacco consumption in New Zealand

Many adult smokers have quit the habit in recent years; but over fifty young people, per day, the majority being young women, continue to take up the use of this addictive substance. To maintain overall tobacco sales it is essential that these young people continue to become addicted.

o Tobacco promotion and smoking by young people

A study detailed in this report, covering data from eighteen countries, shows that there is a relationship between legislation banning tobacco promotion and reduced uptake of the habit by young persons.

o Tobacco promotion by sponsorship

Tobacco promotion through sponsorship of sports and cultural activities has increased in New Zealand in recent years. It helps to give tobacco use in general a glamorous image. It is essential that all forms of sponsorship be included in a ban on promotion. Experience in other countries suggests that, given sufficient notice, alternative forms of financial support can be found by bodies at present receiving sponsorship funding.

o The need for a total ban on tobacco promotion

Experience in many countries shows that partial bans are ineffective or only partially effective. This is because, following a partial ban, the advertising budget is channelled into those avenues which remain legal.

o A comprehensive policy is needed

Studies detailed in this report show that a comprehensive policy is needed to minimise per capita tobacco consumption and the uptake of smoking by young people. The three most important components are (a) raising tobacco prices, (b) public education regarding the health hazards, and (c) a total ban on tobacco promotion.

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o Total bans in other countries

Total bans on tobacco promotion now exist in several jurisdictions, including three Nordic countries, and two Australian states which have banned all tobacco promotion insofar as it is within their powers as states to do so. Most recently Canada has introduced a total ban, effective from 1989.

o Public opinion in New Zealand

Recent independent opinion polls show that a majority of New Zealanders, including a majority of present smokers, favour a ban on tobacco advertising. Approximately half also want sponsorship banned.

o The unique position of tobacco as a legal product

Tobacco use became established hundreds of years before its disastrous effects on health were proven. Any government today would almost certainly ban such a substance if its use among the population had not already become established.

o The conflict of rights and freedoms

Society's right to protect, as far as is possible, the future health of its young people must now prevail over the freedom of the tobacco industry to continue to promote its toxic products.

The Toxic Substances Board recommendations (in brief) are that

(1) Tobacco advertising and sponsorship in all their forms be totally eliminated throughout New Zealand from December 1990.

(2) Specific factual tobacco product information including price only be displayed in specified format at points of sale

(3) The Hillary Commission be associated with any efforts to ameliorate the effects of a sponsorship ban on bodies at present receiving tobacco sponsorship monies.

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SUMMARY

A Introduction

The smoking of tobacco over a period of years causes a wide range of major health problems, problems which cause the deaths of thousands of New Zealanders each year. Approximately one in four of present or past smokers die earlier than those who have never smoked regularly.

In 1986, the Toxic Substances Board, charged under the Toxic Substances Act 1979 with advising the Minister of Health on toxic substances (tobacco being defined as such under the Act), and aware that tobacco causes more deaths than all other toxic substances combined, and that its sale continues because of its addictive nature and widespread use, recommended the elimination of the advertising and promotion of tobacco. The Government did not proceed with this recommendation. The Board's concerns have remained, particularly because:

- o A substantial proportion of young people continue to take up the smoking of tobacco.
- o Lung cancer death rates in New Zealand women have tripled over the past twenty five years and are continuing to rise;
- o Lung cancer death rates for Maori men and women are far higher than for the male and female populations of any other country in the world.
- o Research published since 1986 has highlighted the risks to women from smoking, and extended the known range of diseases due to smoking.

Accordingly, in September 1988, the Board re-established its Tobacco Subcommittee and asked it to review the issue of whether or not tobacco advertising and promotion should be eliminated. It was agreed that the tobacco industry be given the opportunity to put its point of view to the Board.

The Subcommittee considered submissions from the Tobacco Institute of New Zealand and the two major manufacturers; and from tobacco and health experts invited by the industry or the Board from New Zealand and overseas. Tobacco industry representatives made written submissions and met with the Subcommittee on a number of occasions and with the Board on two occasions. The industry's arguments were carefully considered, but the Board concluded that these did not offer a convincing challenge to the weight of evidence, from within New Zealand and overseas, for a total and comprehensive ban on tobacco promotion.

The Board likewise received representations from advertising associations, newspaper publishers and selected sponsored sports and cultural groups, and carefully considered the effects of an advertising ban on affected parties.

The Board or the Tobacco Subcommittee also heard representations from the Cancer Society, the Hillary Commission, and Action on Smoking and Health. (A list of the written submissions is given in Appendix 6.)

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The Board was serviced by staff of the Department of Health and was able to make u: of Department of Health data on smoking in New Zealand, of the databank and publications of the United States Surgeon General, of the International Agency for Research on Cancer publications, and of the World Health Organisation databanks on tobacco use in Europe.

B Tobacco and its effects: a twentieth century pandemic

Tobacco smoke contains over fifty toxic and cancer-causing chemicals. Forty-three of these chemicals are complete carcinogens, sufficient alone to induce malignant change in the cell. Twenty cigarettes yield some 300 milligrams of tar and 30 milligrams of nicotine at the smoker's end of the cigarette. Addiction to nicotine ensures that most users inhale this smoke for decades, a sufficient duration and dose for disease or death to result in about one quarter of cases.

Tobacco deaths worldwide annually equal the adult population of New Zealand. The scientific evidence that tobacco *causes* disease is authoritative and continues to accumulate. The risks of smoking are now greater than previously estimated. Smoking causes a wide range of diseases, and passive smoking can cause fatal diseases in healthy nonsmokers. The tobacco industry's position is that smoking does not cause ill-health. It maintains, for example, that tobacco is only one of many possible causes of lung cancer. The Board accepts the medical evidence that tobacco causes approximately 90 percent of lung cancer deaths, and regards the fact that smoking causes disease and premature death as proven.

> About two-and-a-half million people die every year from all the diseases caused by tobacco. Graphically, we might compare this death toll to the fatal crash of 20 jumbo jets every day of the year.
> - (Dr Halfdan Mahler, Director General of the World Health Organisation, 1987)

C Health consequences for the individual user of tobacco products

The United States Surgeon General has determined (1989) that cigarette smoking is:

- a cause of increased early deaths in men and women
- a cause of increased overall morbidity (sickness rates)
- the major cause of chronic bronchitis
- the major cause of emphysema
- a major cause of coronary heart disease in men and women
- a cause and most important risk factor for atherosclerotic peripheral vascular disease (which can necessitate amputation)
- a cause of cerebrovascular disease (stroke)
- associated with increased mortality from atherosclerotic aortic aneurysm (rupture of the wall of the main artery)
- the major cause of lung cancer in men and women
- the major cause of laryngeal cancer in men and women
- a major cause of cancer of the oral cavity (lip, tongue, mouth, throat)
- a major cause of esophageal (gullet) cancer
- a contributory factor for bladder cancer, pancreatic cancer, and cancer of the kidney
- associated with cancer of the stomach
- associated with cancer of the cervix.

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Not all smokers die from smoking-caused disease, but those smokers who do, die on average 21 years earlier than nonsmokers.

D. Cigarette smoking in New Zealand

Cigarette smoking causes 15 percent of all New Zealanders to die prematurely; over 4,000 New Zealanders die each year from using tobacco (Figure D). This human cost is accompanied by illness care costs, and lost productivity. Over 4,800 person years of working life are lost each year due to tobacco-caused deaths.

Figure D Average annual deaths from cigarette smoking, New Zealand 1981-85

E Trends in tobacco consumption

The percentage of young people in New Zealand who smoke tobacco products is not falling. Indeed, as the Census and recent surveys show, the percentage of young people ages 15 to 24 who are or who have been smokers, has been slowly rising, particularly since 1981.

The percentage of young women taking up daily tobacco smoking dramatically increased between 1976 and 1988. In 1988, more than half of young New Zealand women (under age 25 years) were or had been regular tobacco smokers; over one third are currently smokers. Among youth (15-24 years of age) the percentage of females who smoke any kind of cigarette or tobacco is higher than for males. More women than men in New Zealand smoke manufactured cigarettes. Female lung cancer rates tripled between 1964 and 1988, and are continuing to rise steeply.

Maori people have smoking prevalence and lung cancer rates approximately twice that of the non-Maori population. The rate at which Maori men die of lung cancer rates is higher than for the male population of any country in the world. The rate at which Maori women are dying of lung cancer is higher, in fact nearly twice as high, than for any single country in the world.

F Tobacco marketing, advertising and sponsorship

Point of sale advertising is prominent in New Zealand. Approximately 13,500 outlets, serviced by company representatives, at present provide on their exterior and interiors display space for at least 50,000 tobacco product advertisements, encouraging repeat sales. Tobacco product advertisements appear in almost every issue of major newspapers and magazines. The perimeters of arenas at sponsored sports events, often shown on television, provide important sites where tobacco brandnames are advertised.

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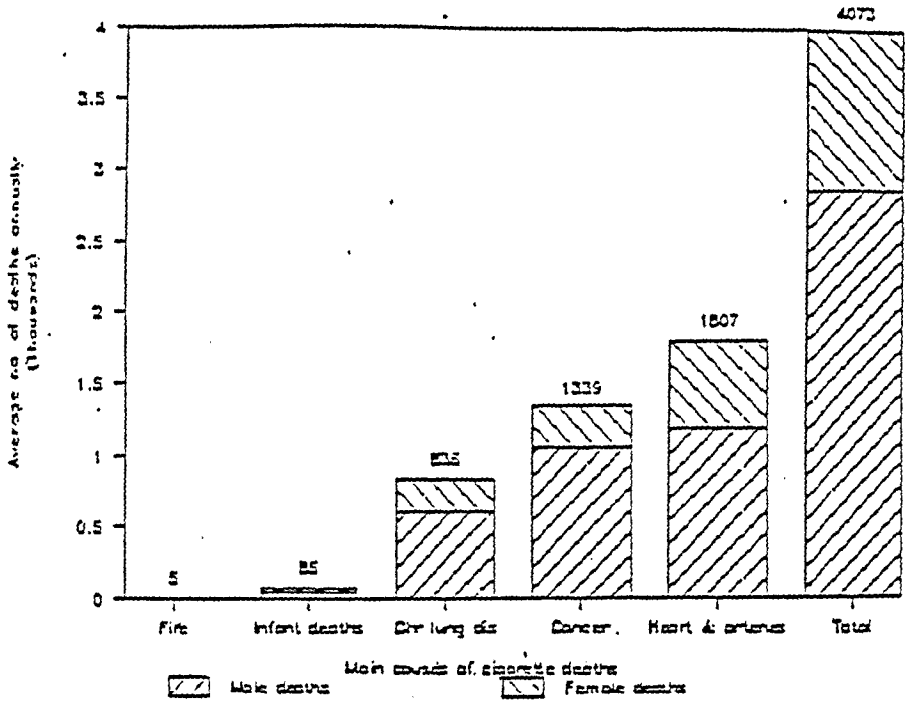
Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

New Zealand, 1981-85



Source: Gray A J, Reinkin J A, Laugesen M.
The cost of cigarette smoking in New Zealand.
NZ Medical J 25 May 1988, 101, 846, 270-3

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

The quantity of tobacco advertising is not controlled, as evidenced by a 60 percent increase in print advertising in constant dollars between 1987 and 1988, despite successive agreements between tobacco manufacturers and the Government since 1973. The tobacco manufacturers spent an estimated $11 million in 1988 on promoting tobacco products and tobacco brandnames. In the past decade, cigarette advertising expenditures in mass media have exceeded anti-smoking publicity by a ratio of over 40 to 1.(Figure F)

Figure F Mass media advertising for and against cigarettes, New Zealand 1979-88

Advertising and sponsorship are promotional methods addressed to the public. Marketing to the trade, product innovation and price variations would allow market competition to continue, and need not be affected by implementation of the recommendations of this report.

G Current controls on tobacco advertising in New Zealand

Agreements on tobacco marketing between the tobacco industry and the Government have existed in New Zealand since 1973. The present agreement, which expires in 1990, provides for a ban on tobacco advertising on television, radio, the cinema and billboards, and controls the size and content of advertising. It does not control quantity or expenditure.

H Tobacco promotion increases tobacco use

The Board heard evidence that cigarette advertising in New Zealand raises cigarette consumption and that, assuming cigarette prices and average incomes remain unaltered, the total elimination of tobacco advertising can be expected to:

- Permanently lower cigarette consumption per adult 7 percent below what it would have been in the absence of a such a ban. This is equivalent to a one-off fall in annual cigarette consumption of over 400 million cigarettes, or over a million a day.
- Lower the proportion of young people who become addicted to tobacco.
- Reduce illness and premature deaths due to tobacco use.

Tobacco manufacturers maintain that tobacco advertising only increases or maintains a tobacco firm's market share.

The Board, having reviewed most of the scientific literature on cigarette advertising in relation to total cigarette sales, and having interviewed and received submissions from the parties involved, finds that advertising does increase total cigarette sales. Experts consulted by the Board estimated that approximately 7 percent of New Zealand's cigarette consumption is due to cigarette advertising. Effects of advertising persuading young occasional smokers to in future become daily smokers are additional to this.

Advertising is as powerful in increasing tobacco use as is price in decreasing its use. Advertising's effect is powerful from a public health viewpoint. The tobacco manufacturers' view was that tobacco advertising only promotes brandswitching and does not increase total sales; but this claim was not substantiated.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

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Advertising in the mass media

Source: Press Research Bureau, Wellington.
Department of Health.

Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

If tobacco advertising increases tobacco use, and tobacco use is fatal to over 4000 New Zealanders per year, then tobacco advertising is responsible for a proportion of tobacco-smoking deaths. Conversely, many New Zealanders would live longer if there was no tobacco advertising.

I Tobacco promotion and children

The tobacco industry drew to the Board's attention a survey in which a cross section of 1000 young people ages 7 to 15 in New Zealand were interviewed about the possible influences of advertising; the children did not mention advertising as a factor influencing their first cigarette. Apart from the fact that most people of any age deny that advertising affects them, smoking one cigarette is not the same as taking up daily smoking. This study did not illuminate the role of tobacco advertising during the period (over two years on average) between first cigarette and establishment of daily smoking.

The Dunedin Multidisciplinary Study, which has followed nearly 1000 Dunedin children from birth to age 15 years, found that 80 percent of children had experimented with tobacco by age 15. When the children who had been early experimental smokers were seen at age 15, they were no more likely to be daily smokers than those who had not been early experimental smokers.

Children in New Zealand are exposed to cigarette advertising, and their knowledge of brands indicates that the advertising is seen and remembered.

A survey of 10- to 12-year-old New South Wales children showed that those who approved of tobacco advertising were more likely to take up smoking in the following year than those who did not approve of such advertising. The difference between the two groups was 15 percentage points. Also, smokers at this age who approve of the advertising were found to be less likely to quit smoking in the following year than smokers who did not approve of the advertising.

J Tobacco sponsorship advertising

Tobacco sponsorship provides less than 2 percent of total sponsorship funding of sports, arts and culture, yet dominates summer sport on television. Tobacco sponsorship is advertising and is designed to increase awareness for tobacco brandnames, and functions as advertising to children.

K Effects of banning tobacco promotion in other countries

Tobacco advertising is completely banned in 18 countries. In the group of countries where tobacco advertising has been completely banned for health reasons, that is, Iceland, Finland, Italy, Norway, Portugal, tobacco consumption per adult has been falling for some years. For nine East European countries where advertising of any kind has been banned for political reasons, tobacco consumption per adult is now falling in five, and is also falling for the group as a whole. Canada banned tobacco promotion in 1988, and it is too early to report results.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

The inter-relation of tobacco advertising and tobacco consumption were examined in thirty three countries in a study commissioned by the Board, covering the years 1970 to 1986. The study showed (Figures K and L) that:

- o Government tobacco advertising bans and controls are accompanied by marked rates of fall in tobacco consumption and in tobacco smoking prevalence; in the absence of any such control, consumption increases markedly.
- o Total advertising bans for health reasons are, on average, accompanied by falls in tobacco consumption four times faster than in partial ban countries.
- o The annual rate by which tobacco consumption falls is graduated, with maximum fall in total ban countries (average, -1.6 percent per year)
- o Much slower declines in consumption (-0.4 percent per year) are seen in countries where tobacco promotion has been permitted in some media.
- o In countries where tobacco has been promoted virtually unrestricted in all media, consumption has markedly increased (+1.7 percent per year).
- o In countries where advertising has been totally banned or severely restricted, the percentage of young people who smoke has decreased more rapidly than in countries where tobacco promotion has been less restricted.

Figure K Tobacco advertising restrictions and percentage change in tobacco use/adult; 33 countries

Figure L Tobacco advertising restrictions and rate of change in percentage of adults smoking: 20 countries

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Overall. the study found that the greater a government's degree of control over tobacco promotion, the greater the annual average fall in tobacco consumption and in the rate of decrease of smoking among young people. In total ban countries compared with the group of countries without controls, tobacco consumption fell more rapidly, and this effect could not be explained away by tobacco price or income per capita trends. The elimination of tobacco advertising, other factors being equal, more likely than not, *causes* tobacco consumption to decrease.

In an investigation into whether advertising bans impede the flow of information, in thirty countries for which data were available, tobacco advertising bans were found to have no relationship to the rate at which filter-tips increased their share of the market. Average tar yields from cigarettes in countries where health-inspired tobacco promotion bans are in effect, such as Norway and Finland, are *lower* than in many other countries. The Board considers that advertising bans do not impede the free flow of product information. Governments do not have to rely on advertising to inform consumers about tobacco products sold. Warning requirements can be extended by governments to include the insertion of printed slips into all tobacco product packages.

L More detailed findings from countries where tobacco promotion has been banned

The findings were: (1) bans on tobacco promotion are associated with a lowering of tobacco consumption; (2) bans on tobacco promotion are effective when part of a total health policy package aimed at lowering tobacco consumption.

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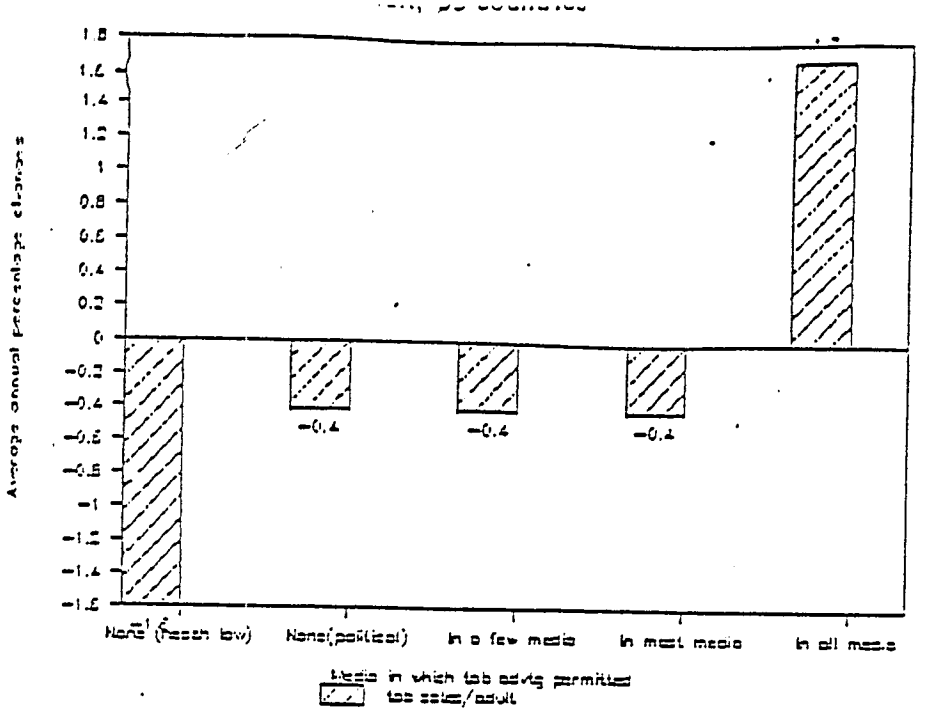
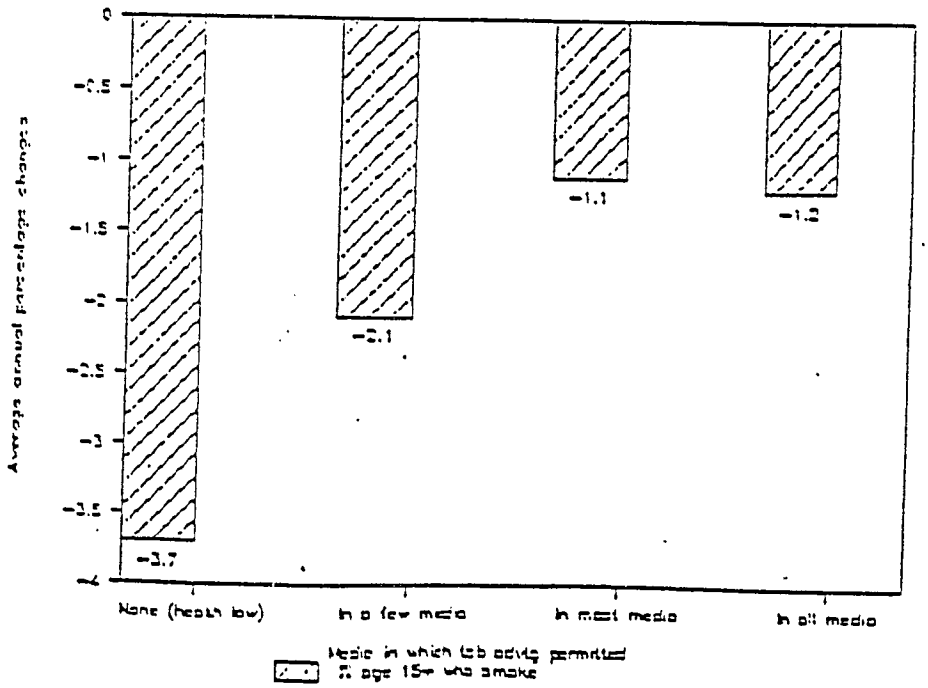


Fig L Tobacco advertising restrictions and rate of change in percentage of adults smoking (20 countries)



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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

In the 1970s, Iceland, Norway and Finland implemented Tobacco Acts banning tobacco advertising and mandating health education. Tobacco consumption is gradually falling in these countries.

Iceland banned advertising in 1972; its tobacco consumption peaked in 1975. Norway banned advertising in 1975 and consumption peaked in that year. In Finland, tobacco consumption peaked in 1974. Portugal banned tobacco advertising in 1983 and consumption peaked in that year (Table 2).

Adbans work. Despite the slow rates of decline in Nordic countries since tobacco promotion was outlawed, total bans on tobacco promotion have helped to hold down consumption. These countries as a group have experienced marked income growth since 1970, and cigarettes have become more affordable. A packet of cigarettes now costs a smaller fraction of personal income in these countries than in 1970. Normally, increased affordability should have raised consumption. It has not.

Since 1970, tobacco sales per adult have fallen more gradually in these Nordic countries than in New Zealand, but the ban on tobacco promotion has ensured that their tobacco consumption levels are unlikely to rise to the high levels previously experienced in New Zealand.

The percentage of youth (ages 15-24 years) who smoke has fallen more rapidly in Norway and Finland since the Tobacco Acts were passed, compared with New Zealand.

Analysis of the Nordic countries' situation shows that a total ban on tobacco promotion helps greatly to reduce tobacco consumption. Bans on promotion without increases in tobacco taxation are not effective, as Finland found. A ban has to be enforced, as Italy discovered. This includes elimination of the advertising of tobacco brandnames on non-tobacco goods, as Belgium and Italy found.

East European countries

Politics, and not health, was the original reason for advertising bans in East European countries. Tobacco smoking has increased in these countries since 1970; in some of them this is due to the fact that tobacco prices remained constant for decades while personal incomes grew. As health concerns slowly increased, between 1980 and 1986, tobacco consumption fell in five out of nine of these countries, despite growing personal incomes. The fall in tobacco consumption averaged 0.4 percent per year among this group of countries. If unrestricted tobacco advertising had been allowed in Eastern European countries, as in nearby Greece, for example, it seems likely that smoking would still be increasing.

Even though the bans on promotion were imposed for political reasons, the falls in tobacco consumption seen since 1980 argue for continued bans on tobacco promotion in East Europe, backed with more health education and other measures.

M Health policies to promote nonsmoking

Comprehensive policies to reduce tobacco consumption - combinations of health education, taxation, a ban on tobacco promotion, enforcement of laws against selling tobacco to children - are much more effective than any single measure.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Comprehensive anti-tobacco policies are recommended by the World Health Organisation, and in New Zealand a succession of expert committees have given similar advice. As a former Director General of the World Health Organisation has stated:

> As tobacco use is a multifaceted problem, multiple approaches are needed to tackle it. Among these are: legislation to restrict smoking and limit the promotional power of the tobacco industry...

The three essential features for an effective government policy to reduce the health consequences of tobacco use are:

- o educating the public about the dangers of tobacco use.
- o raising tobacco prices.
- o a total ban on tobacco promotion.

The long-term goal is for a smokefree society where:

- o There are smokefree environments.
- o Adults are free to choose to smoke or not, without persuasion to smoke (from tobacco promotion).
- o The younger generation can grow up free of tobacco addiction - a smokefree generation.

A smokefree society does *not* mean prohibition on the sale of tobacco to adults; prohibition is not a realistic option.

The Board believes that the provisions in the voluntary agreement between government and manufacturers have been useful, but that real progress in promoting nonsmoking will not occur until comprehensive strategies are in place, including a complete ban on all tobacco advertising and sponsorship.

N Public opinion

A growing majority of New Zealand's adult population (65 percent of those aged 15 and over in 1987), including more than half of smokers, wants a ban on tobacco advertising; a growing minority (47 percent in 1988) wants tobacco sponsorship banned.

The Social Services Committee of Parliament in 1988 gave favourable recommendation to a petition to ban tobacco advertising and promotion.

O Principles

The Toxic Substances Board, having regard to:

- o the very large annual death, disease and disability toll from disease caused by smoking and
- o the fact that young people continue to take up smoking in large numbers,

adopts the following principles:

- o The promotion of nonsmoking should be a major priority for any health service.

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- Everything possible should be done to ensure that young people do not start smoking or continue smoking.
- A toxic substance which is known to cause over 4000 New Zealand deaths a year should not be advertised as fit for human consumption, let alone associated with any healthy, vigorous, glamorous or well-publicised activity.
- No government agency should feel it must prove that tobacco promotion causes young people to begin smoking before it will consider steps to eliminate tobacco promotion.
- Such a policy can be recommended even if there is no certainty of any immediate decline in teenage tobacco use.

Conclusion

The Toxic Substances Board concludes that tobacco promotion is harmful to the public's health and welfare, and that it is destructive of the future health and lives of thousands of today's young people. In New Zealand, over fifty young people on average per day become daily tobacco smokers - a number that can be reduced if tobacco promotion is eliminated. Society's need and right to pass laws to protect the future health of its young people must now prevail over the freedom of the tobacco manufacturing industry to continue promoting its toxic product.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

RECOMMENDATIONS TO THE MINISTER OF HEALTH

The Board recommends to the Minister of Health that:

1) Tobacco promotion in all its forms be totally eliminated throughout New Zealand from December 1990.

   The concept of 'tobacco promotion' applies to the advertising of tobacco products and accessories, includes tobacco industry sponsorship, tobacco corporate advertising, free or subsidised distribution of tobacco products, coupons, contests, and any other new form or old form of direct tobacco advertising, and applies also to the indirect advertising of any other goods using any tobacco product brandname or logo.

2) Only two exceptions should be permitted:

   - The display of specified factual tobacco product information, including price, in specified format at point of sale.

   - Tobacco advertising in foreign magazines and newspapers (this exception not to include any New Zealand edition).

3) Government should ask the Hillary Commission

   - To consider the impact of the elimination of tobacco sponsorship on those sporting, cultural and other groups who are presently dependent to some extent on it, and to take a role in any action that may be decided.

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PART I TOBACCO AND ITS EFFECTS

1 A PROFILE OF TOBACCO

Summary

Tobacco smoke contains over fifty toxic and cancer-causing chemicals. As indicated by the information on the packet, twenty cigarettes yield some 300 milligrams of tar and 30 milligrams of nicotine at the smoker's end of the cigarette. Addiction to nicotine ensures that most users inhale this smoke for decades, a sufficient duration and dose for disease or death to result in about one quarter of cases.

1.1 Toxicity

Tobacco, whether prepared for smoking, chewing, snuffing or any other oral use, is a toxic substance. It is defined as such in the Toxic Substances Act 1979.[1]

The toxicity of tobacco is related to

- the known toxic properties of nicotine (nicotine is a powerful poison affecting heart and blood vessels, and is an addictive agent);
- biologically active substances either in tobacco or generated by its combustion, such as carbon monoxide, hydrogen cyanide and ammonia; and
- the known cancer-causing properties of chemicals in tobacco smoke.

1.2 The cancer-causing properties of tobacco

Tobacco smoke, including its particulate matter (tar solids) contains over 4000 chemicals.[2] Ninety-nine of these have been studied in detail. Fifty-nine biologically active compounds - toxic, carcinogenic (cancer causing) and mutagenic (causing changes in cell chromosomes) - had, by 1986, been identified in mainstream smoke.[3]

Of the chemicals in cigarette smoke, forty-three are complete carcinogens (materials which alone and unaided can induce malignant changes). Among the carcinogens in tobacco smoke, certain volatile nitrosamines, substances found only in tobacco or the gas phase of tobacco smoke, are potent carcinogens in animal models.[4]

The cancer-causing properties of tobacco are particularly related to the tar condensate, but not confined to it, and many cancer-causing chemicals are found in the gas phase of the smoke.

The consequences and human cost of this toxicity, dealt with in Chapters 2 and 3, follow from the ordinary use of tobacco, and whether the person smokes heavily or not.

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1.3 Nicotine and the addictive properties of tobacco

> I used to smoke. I started at university in the fifties. By the early seventies I was hitting 60 a day. I had perpetual sore throats. But I kept smoking. My doctor warned me that cancer was on the cards within two years. But I kept smoking. I suffered from lingering colds, coughs, bronchitis, asthma. But I kept smoking. I lost more and more days off work. But I kept smoking.... Inevitably, I ended up in hospital having unspeakable things done to my larynx. I stopped smoking. Almost a decade later I felt the urge for one puff of a cigarette. Within a fortnight I was back on 40 a day. I kicked the habit again three years ago. Like every other smoker in the world, I'm a smokaholic, a nicotine junkie.. I know what it's like to be an addict and to be asked to give up your addiction. I know what it's like to be dying for a fag. I know what it's like to regard the prospect of life without cigarettes as intolerable... Giving up smoking is difficult, but it isn't like going cold turkey on heroin. You're irritable and difficult to live with for a couple of weeks and you have cravings for a cigarette for another couple of years or maybe longer. But there's nothing in there that can really be called pain...[5]

Nicotine is the addictive element in tobacco. The criteria for addiction, as internationally recognised by such bodies as the World Health Organisation, the Office of the United States Surgeon General, and the American Psychiatric Association, are met when:

- A psychoactive substance is present, that is, a substance which produces transient alterations in mood that are primarily mediated by effects in the brain. Nicotine, a powerful pharmacological agent, acts in the brain and throughout the body. It readily crosses the blood-brain barrier.

- There is compulsive use of the drug despite knowledge of its dangers to the individual or to society. The New Zealand Cancer Society poll of November 1987 indicated that most smokers do know that smoking cigarettes incurs serious health risks, and the majority (67.5 percent) want to give up.[6] The majority in this poll said they would find it difficult to give up smoking for a week. In Canada in 1986 a Gallup poll showed that 76 percent considered 'cigarette smoking to be like a drug addiction' and 80 percent of current smokers answered yes to the question 'Do you think you are addicted to cigarettes.'[7]

- The drug is 'reinforcing' for tobacco-seeking, tobacco-using behaviour. In other words, the drug's pharmacological activity is sufficiently rewarding to maintain self-administration.

- Over time a given dose of a drug produces less effect, and increasing doses are required to achieve a specified intensity of response.[8]

- Physical dependence, characterised by a withdrawal syndrome, is evident. This dependence is indicated by the fact that cigarettes have to contain a certain amount of nicotine before they will satisfy smokers - nicotine-free tobacco substitutes have been market 'flops'.

- After cessation of drug use, there is a strong tendency to relapse. Most smokers have made at least one attempt already to give up smoking.[9] The cure rate one year after treatment in smoking cessation clinics is low, about 20 percent, similar to relapse rates with other drugs of addiction treated in clinics, although there is great variation between individuals in the difficulty of giving up their particular drug of addiction.[10]

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o Addictive behaviour can involve recurrent drug cravings. This is the personal reality of tobacco addiction, as attested to in the quotation that begins this section. At a meeting of the Tobacco Subcommittee of the Toxic Substances Board, the Tobacco Institute called on Professor David Warburton from Reading University, England, who attempted, among other matters, to dismiss the idea that tobacco use is addictive as stated by the United States Surgeon General. Professor Frederick Fastier, of Otago University, called as an expert by the Board, convinced the Subcommittee that the Surgeon General's view regarding addiction is correct. The Subcommittee recognised, however, that the degree of addiction among smokers varies widely. As the United States Surgeon General's 1988 report concludes:

> An extensive body of research has shown that nicotine is the drug in tobacco that causes addiction...the processes that determine tobacco addiction are similar to those that determine addiction to other drugs, including illegal drugs. Spontaneous remission and occasional use also occur with the illicit drugs of addiction, and in no way disqualify a drug from being classified as addicting.[11]

The immediate past Director General of the World Health Organisation, Dr Hafdan Mahler, has taken a similar position. In November 1987 at the 6th World Conference on Smoking and Health, he stated that '...tobacco has been shown to be as addictive and as dependence producing as hard drugs'.[12]

These conclusions of scientific and health bodies accord with the commonsense understanding of tobacco - that it is extremely difficult to stop using.

It is not a part of the definition of an addictive drug - in either the scientific or commonsense understanding of the concept - that *all* users become addicted, or that once addicted they cannot become 'unhooked'. Clearly, not all smokers are addicted, and some manage to be light or social smokers for many years. The importance of environment is indicated by the fact that more than 70 percent of American servicemen addicted to heroin in Vietnam overcame that addiction on return to the United States, where they experienced a complete environmental change and the elimination of drug-associated stimuli.[13] (Nicotine addicts cannot escape drug-associated stimuli, which, in most countries, are augmented by tobacco advertising.)

Similarly, the fact that the majority of people who drink alcoholic beverages are occasional or social drinkers does not stop society, or the alcohol industry, from recognising that alcohol is addictive for a number of drinkers.

The psychological aspects of tobacco dependence are no less serious than the physical aspects, as evidenced by the cure and relapse rates. Although it is true that tobacco dependence does not involve the disorder and crime associated with illegal drugs, this to some extent stems from the historical accident of the legality of tobacco.

The fact that tobacco and the nicotine it contains are addictive is crucial, because it ensures that people take tobacco for many years. Many years' duration of smoking is essential for the development of most tobacco-caused disease which, as outlined in the following sections, is the leading cause of premature death in the developed world, and increasingly in the developing world also.

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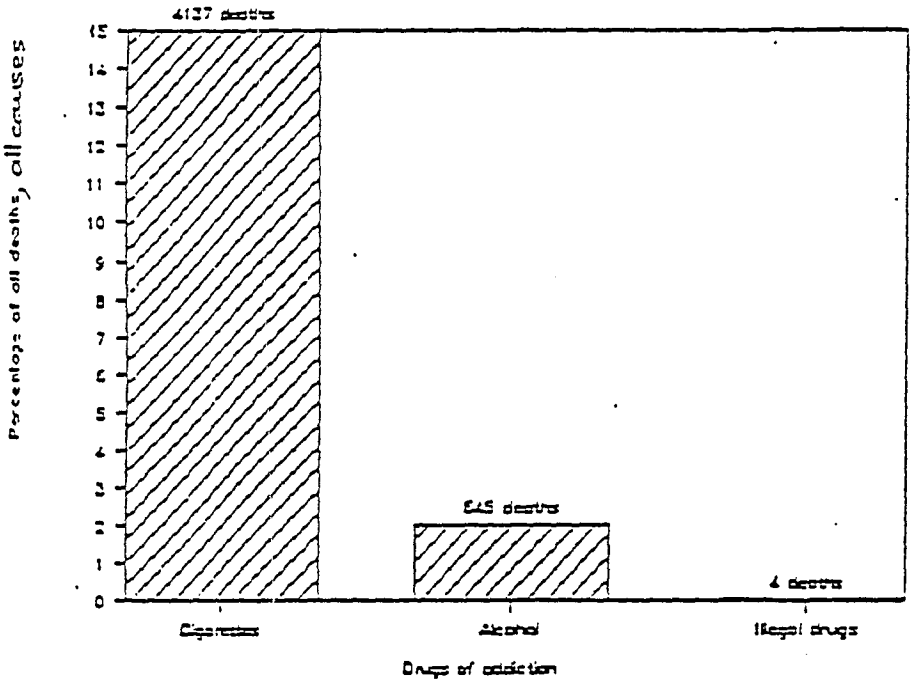
According to the National Institute of Drug Abuse in the United States, nicotine is 'our most deadly addictive drug'.[14] Tobacco clearly causes more sickness, more avoidable death and more untimely bereavement than all other drugs combined (Figure 1.3)

Figure 1.3 Percentage of all deaths due to drugs of addiction, New Zealand, 1985

Fig 1.3 Percentage of all deaths due to drugs of addiction, New Zealand, 1985



Source: Gray A J, Reinkin J A, Laugesen M.
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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

2 THE HEALTH CONSEQUENCES OF TOBACCO USE

Summary

Tobacco deaths worldwide annually equal the adult population of New Zealand. The scientific evidence against tobacco is weighty, and sufficient to convince the Toxic Substances Board beyond a shadow of doubt. The evidence continues to accumulate, and the risks of smoking now appear to be greater than previously estimated. The risks for women who smoke are also greater than previously estimated. Smoking causes a wide range of diseases, and passive smoking can cause fatal diseases in adult nonsmokers. Smoking is now recognised as a major cause of stroke. Smokers who die of smoking die on average twenty-one years earlier than the average age of death.

2.1 The global health consequences of tobacco use

> About two-and-a-half million people die every year from all the diseases caused by tobacco. Graphically, we might compare this death toll to the fatal crash of 20 jumbo jets every day of the year. In developed countries, cigarettes are linked to at least 80 percent of all deaths from lung cancer, to 75 percent of deaths from chronic bronchitis, and to 25 percent of deaths from heart disease... While the numbers of men who smoke are on the decline, the numbers of women smoking are rising. In particular, more teenage girls, our daughters, are being hooked on the habit.[1]

2.2 The evidence

The evidence against tobacco has been massive for twenty-five years and becomes weightier as each year goes by.

- The adverse health effects of tobacco use are a matter of scientific record since 1939, and particularly since 1950, when five studies were published showing increased lung cancer risks in smokers.[2]

- Tobacco industry executives and scientists were among the first to know that cigarettes were dangerous to health. Evidence produced before a United States court in 1988, in the case of Rose Cippolone versus Myers Ligget, showed that it was known to that tobacco company in the early 1950s, from the work of American scientists, that tar from cigarette smoke painted on the backs of mice caused cancer to develop in these animals. (Rose Cippolone died of lung cancer and her family were awarded damages.[3])

- By 1954 the first large study relating smoking to death rates was published.[4] Further studies in the United States and Britain followed. These were even larger, and involved the tracking of more than two million smokers and nonsmokers over many years to compare their fate (see Appendix 1, Table A1.1).

- The first report of the United States Surgeon General on smoking and health, in 1964, showing that smoking causes lung cancer and is linked to other diseases, was based on study of 7000 scientific articles.[5]

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- In January 1964, under prominent headlines, newspapers around the world and in New Zealand published the main finding of the first report on smoking from the United States Surgeon General's report - smoking caused lung cancer. Ten years passed before cigarette manufacturers in New Zealand, under pressure from government, had placed warnings on cigarette packets. No mention, however, was made of lung cancer in the warning.[6]

- Since 1964 a succession of reports from the United States Surgeon General on the health consequences of tobacco use have served to summarise much of the scientific evidence.[7] Equally authoritative reports have been published by the Royal College of Physicians in London.[8]

- The scientific evidence against smoking is today based on over 30,000 articles, found in a very wide range of scientific publications, in many languages. This scientific data base is accessible to the public through libraries and their national and international bibliographic networks.[9]

- In short, the evidence on the adverse health effects of tobacco use is overwhelming - and convincing. To take just one example: in a 1985 letter to the Minister of Health on the effect of smoking on disease, the Colleges of Medicine, representing virtually all specialist doctors in New Zealand, noted that:

> Few other topics in medicine have generated such serious concern in all branches of our profession as the effect of smoking on health. We know of no other area in medicine where there is such unanimity.[10]

In response to the unanimity on the evidence, the Toxic Substances Board in 1986 recommended a variety of stronger health warnings on tobacco packets. At the direction of the Minister of Health, new warnings appeared on all cigarette packets in New Zealand from December 1988. The scientific evidence supporting this move is summarised in Appendix 1.

2.3 The evidence updated

2.3.1 Diseases caused by smoking

The 1989 report of the United States Surgeon General summarises the current state of scientific consensus on the death and disease consequences of smoking, and the main points are tabulated here. (The relevant current warnings on cigarette packets in New Zealand are shown bracketed in italics.[11]) The Surgeon General has determined that cigarette smoking is:

- a cause of increased premature overall mortality in men and women;
- a cause of increased overall morbidity (sickness rates) *(Smoking causes fatal diseases)*;
- the major cause of chronic bronchitis;
- the major cause of emphysema *(Smoking damages your lungs)*;
- a major cause of coronary heart disease in men and women *(Smoking causes heart disease)*;
- a cause and most important risk factor for atherosclerotic peripheral vascular disease (which can necessitate amputation)
- a cause of cerebrovascular disease (stroke);

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- o associated with increased mortality from atherosclerotic aortic aneurysm (rupture of the wall of the main artery);
- o the major cause of lung cancer in men and women *(Smoking causes lung cancer)*;
- o the major cause of laryngeal cancer in men and women;.
- o a major cause of cancer of the oral cavity (lip, tongue, mouth, throat);
- o a major cause of esophageal (gullet) cancer;
- o a contributory factor for bladder cancer, pancreatic cancer, and cancer of the kidney
- o associated with cancer of the stomach; and
- o associated with cancer of the cervix.

2.3.2 Trends in the estimated risks for those who smoke

On a basis of a comparison of the fate of smokers versus nonsmokers in 1982-86 versus 1959-65, in two separate American Cancer Society studies each involving over 1 million men and women over 45 years of age, the risks for smokers versus nonsmokers are now estimated to be greater than previously calculated (Figure 2.3). Specifically,

- o for men and women under age 65, for coronary heart disease (heart attacks), double the previously estimated risks;
- o for men and women, for cancer of the lung, double the previously estimated risks;
- o for men of any age, for stroke, double the previous risk estimate; and
- o for stroke in men and women under age 65, double the previous estimate.

By smoking, the average American male in the 1980s increases his risk of lung cancer twenty-two times, while the average American woman increases her risk twelve times.

Figure 2.3 Relative mortality risks, nonsmokers (= 1.0) versus smokers

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Source: . *Reducing the Health Consequences of Smoking. A report of the Surgeon General* 1989, U.S. Department of Health and Human Services Tables 4 to 8, p. 148-153.

2.3.3 Risks for women who smoke, compared with risks for male smokers

The risks for women who smoke are great, and much greater than previously realised. The first studies on lung cancer and smoking were on men; many of the earlier studies had insufficient women smokers to allow strong conclusions to be drawn. The first four years of results from the second American Cancer Society study commenced in 1982 are now available. The fates of these two-thirds of a million women were tracked through to 1988. It is now estimated that even if the population of the United States had remained the same from 1965 to 1985, the number of women dying from cigarette smoking *doubled* in these two decades, directly related to the fact that more women had taken up lifelong smoking, especially from the teenage years onwards.[12] The specific risks are as follows:

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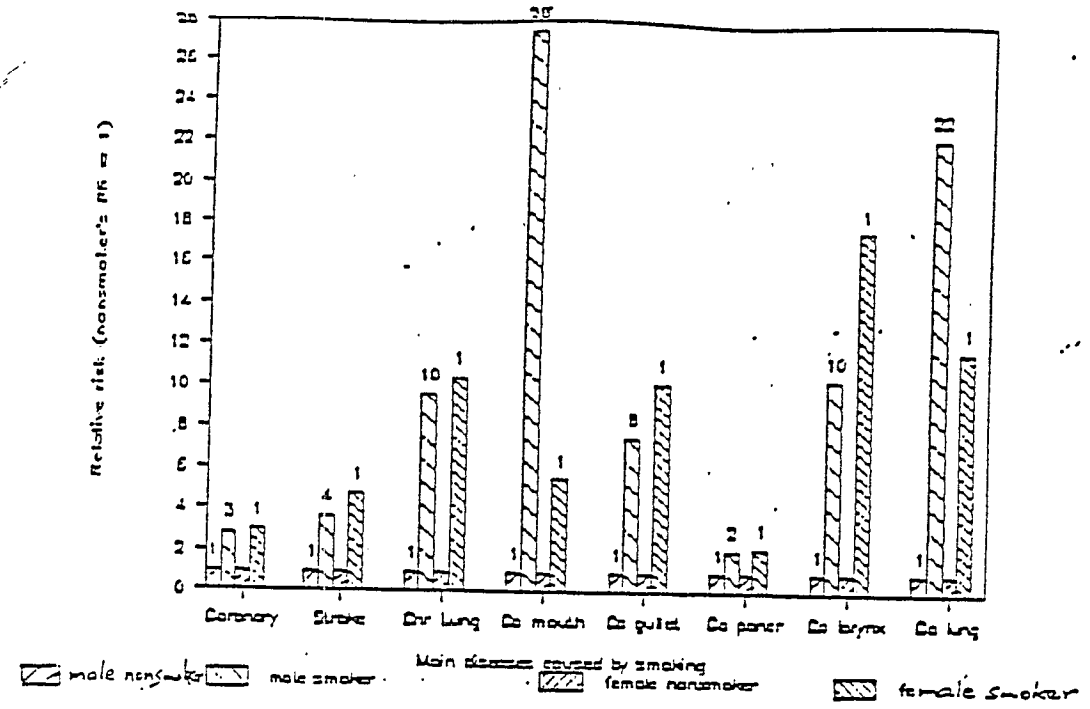
Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000



Source: Reducing the Health Consequences of Smoking: A report of the (U.S.) Surgeon General 1989
U.S. Dept. Health & Human Services. Tables 4 to 8

Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

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- *Heart attacks*: Among younger women (under age 65) smoking now accounts for nearly half the coronary deaths in the United States. Oral contraceptive use among women smokers is known to escalate the risk of heart attack.
- *Lung cancer*: In the United States 79 percent of lung cancer mortality in women is now due to smoking.[13]
- *Stroke*: Smoking accounts for more than half of fatal strokes in women under 65 in the United States. Women under 65 who smoke have greater risks of stroke than male smokers of the same age.[14]

2.3.4 The personal risks of smoking: effects on life expectancy

One in three heavy smokers on average dies before age 85 of diseases caused by smoking.[15] A male smoker in his thirties smoking two packs a day dies on average eight years sooner than a nonsmoker.[16]

Not all smokers die from smoking-caused disease, but those smokers who die from smoking die on average twenty-one years earlier than nonsmokers.[17]

2.3.5 Risks for others from smoking

Cigarette smoking is a cause of disease, including lung cancer, in healthy nonsmokers.[18]

If a woman smokes in pregnancy -

- the risk of spontaneous abortion is markedly increased;[19]
- the risk of the baby being of low birthweight (under 2,500 grams) is increased by over 50 percent for light smokers and 130 percent for heavy smokers;[20]
- the risk of stillbirth and of death in the child's first month is increased by nearly 30 percent.[21]
- the risk of post-neonatal death is significantly increased.[22] the risk of cot death (sudden infant death syndrome) is more than doubled[23,24]
- the likelihood of the infant contracting pneumonia, bronchitis and bronchiolitis in the first year of life is doubled;[25]

If the mother smokes after the birth -

- the risk of cot death is more than doubled[26]

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

NOTES TO CHAPTER 2 - THE HEALTH CONSEQUENCES

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

3 THE HUMAN COST OF CIGARETTE SMOKING IN NEW ZEALAND

Summary

Cigarette smoking causes 15 percent of New Zealanders to die prematurely, totalling over 4000 deaths annually. This human cost is accompanied by illness care costs and lost productivity. Over 4,800 person years of working life are lost each year due to smoking-caused deaths.

The first New Zealand estimate of deaths due to smoking was 3,600 deaths per year.[1] Industry consultants queried these estimates on the basis that they vary. The estimates are bound to vary because the numbers exposed to risk from tobacco smoking vary from year to year, and the range of diseases known to be caused by smoking has increased (See 2.3). The present estimates are, if anything, underestimates. The real issue is that the manufacturers of tobacco products in New Zealand do not admit that a very large number of deaths are due to smoking in New Zealand each year.

3.1 Death and illness

- Maori men and women have one of the highest recorded incidences of lung cancer in the world2 (Table 4.3.1).

- In 1985, 15 percent of deaths in New Zealand were attributed to cigarette smoking - 22 percent of all male and 10 percent of all female deaths. Passive smoking deaths and cigar and pipe smoking deaths were not included in this figure; therefore, the true estimate is probably higher.3

Smoking accounts for 22 percent of cancer deaths in New Zealand. In other words, over one-fifth of present cancer deaths would be avoidable if no one smoked.[4]

In Maori women, who have one of the highest smoking and highest lung cancer rates of women anywhere, lung cancer has surpassed cancer of the breast or of any other site as the leading fatal cancer.[5]

Each year in New Zealand, 4,815 years of working life (those years between the ages of 15 and 60) are lost by New Zealanders due to premature death induced by cigarette smoking. One in five deaths of men aged 15 to 60, and one in nine of deaths of women of this age, are attributable to smoking.[6]

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Table 3.1 Average number of deaths per year due to cigarette smoking in New Zealand, 1981-85

Type of smoking death	Men	Women	Total
Circulatory disease	1192	615	1807
Cancer	1049	290	1339
Bronchitis/emphysema	615	221	836
Fire	3	2	5
Deaths in infancy			86
Total	2859	1128	4073

Source: Gray, A.J., Reinken, J.A., and Laugesen, M. The cost of cigarette smoking in New Zealand *New Zealand Medical Journal*. 101 (846) 25 May 1988, p. 270-3, Table 3. This table is based on the average estimated deaths attributable to cigarette smoking in the five years 1980-82 and 1984-85.

3.2 Smoking costs

Smoking costs! It costs the individual, it costs the family and it costs society at large. The health and financial costs for the individual smoker have been well documented; similar costs for the non-smoker (often family, friend or work colleague of a smoker) are being increasingly recognised. The costs for society have been shown as monumental.

It is the family which tends to bear the brunt of the grief and suffering occasioned by illness and death brought about by tobacco use. At this level, the human costs are all too evident.

For many people, the human costs to society at large may not be so apparent. But costs there are - costs which have an adverse impact on a country's ability to channel its financial resources into areas beneficial to all its citizens. One such cost is that of smoking-induced hospitalisation, estimated at $100 million dollars annually. On average, 828 hospital beds are occupied at any one time by patients with illness attributed to smoking. This totals 302,000 bed-days annually.[7] Pharmaceuticals to treat coronary heart disease due to smoking cost the taxpayer an estimated $16 million in 1988.[8] Visits to general practitioners for smoking-caused illnesses cost approximately $9 million per year in 1985, a cost mainly borne by the public.[9]

Other costs to society include lost productivity due to smoking rituals, extra cleaning and refurbishing of worksite and other accommodation, insurance, forest and other fires, and widows' pensions. Workers who smoke suffer more sickness, and are more often absent from work than nonsmokers.[10]

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Some people argue that society benefits from tobacco use through the tax revenue generated by it. Tax, however, is not new wealth, only a transfer payment from one section of society to another. Others argue that the taxpayer benefits from smokers because many do not survive to collect their superannuation. Such arithmetic ignores the social cost involved in the decreased quality of life for smokers and for those affected by their ill-health and lowered life expectancy.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

3 NOTES AND REFERENCES ON THE HUMAN COST OF CIGARETTE SMOKING IN NEW ZEALAND

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

4 CIGARETTE SMOKING AMONG YOUNG PEOPLE, WOMEN AND MAORI

4.1 Smoking among young people

Summary

As the Census and recent surveys show, the percentage of young people age 15 to 24 who are or who have been smokers is still slowly rising, particularly since 1981. The decrease in the percentage who smoke between 1976 and 1988 has been slight.

Since 1980, the percentage of children who have tried a cigarette appears to be on the increase. In 1987-88, among Dunedin 15-year-olds, for example, 81 percent of the girls and 78 percent of the boys had experimented with tobacco smoking. Up to the age of 11, however, experimentation with one cigarette was found to not correlate with daily smoking in the same child at age 15.[1]

The formative years for smoking according to the Dunedin birth cohort are between 10 and 13 years of age. By age 15, 33 percent of girls and 20 percent of boys were found to be daily or monthly smokers - 27 percent overall.[1]

Of 15-year-old boys and girls combined, 15 percent were found to be daily smokers (Figure 4.1). These young people are probably addicted, and may well smoke for most of their adult lives. Twelve percent were deemed occasional smokers (one or more cigarettes per week or per month); their future smoking habits are less clear. Sixty- two percent of the 15-year-old smokers (both daily and occasional) were girls.[1]

Figure 4.1.1 Percentage who smoke among 966 Dunedin 15-year-olds, 1987-88

The extent to which occasional smokers amongst young people become daily smokers is important, for it is the main unknown factor in respect of future tobacco sales and consumption.

The situation in New Zealand contrasts with what has occurred in a number of other developed countries, for example, Norway, Finland and Iceland, which have seen a reduction in the percentage who are daily smokers in most age-gender groups of young people (see 8.2, 8.3 and 8.4).

Census and survey data show that young people in New Zealand, that is, those aged 15-24, are now taking up regular smoking more than at any time since records began in 1976; over half the total of young people in this age group are or have been regular smokers. Fortunately, evidence from the same sources shows that an increasing proportion of youth are quitting smoking before age 25, but the net result is that the percentage in this age group who smoke has only fallen two percentage points in twelve years. This contrasts with a one-third reduction between 1983 and 1988 in the percentage of men age 55 and over who smoke.[2]

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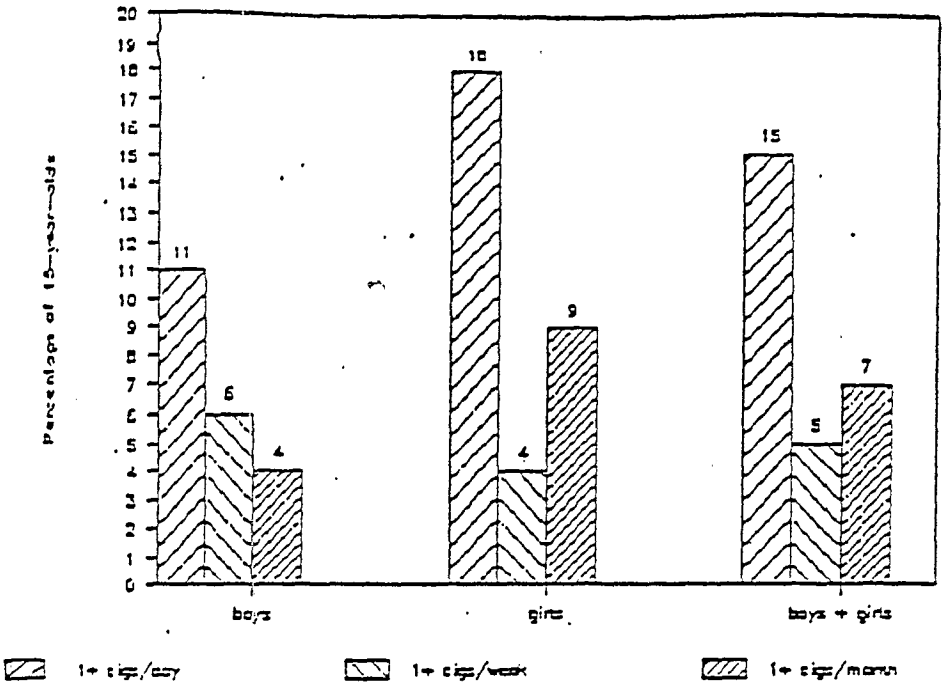
Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000



Source: Silva P A, Dunedin multidisciplinary Study, University of Otago, Dunedin. In press.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Figure 4.1.2 Cigarette smokers, age 15-24 years, New Zealand, 1976-88, as a percentage of their age group.

Almost as quickly as smokers die or quit, their ranks are replaced by young smokers. The smoking population in New Zealand, therefore, is currently in a state of dynamic equilibrium, with virtually no reduction in the number of people at risk from tobacco use between 1981 and 1988. (Table 4.1.3).

Continued high levels of recruitment to smoking ranks of teenagers, particularly young females, are helping to maintain a high percentage of smokers in the population. There are 193,000 regular smokers aged 15 to 24 years[3] (whose smoking habit probably began before age 15) and approximately one-tenth of this number attain their twentieth birthday each year, including one-tenth of the smokers. Thus the 15 to 24 age group can be regarded as providing approximately 19,300 new smoking recruits to the adult smoking population each year, or over 50 *new* customers each day for tobacco products.

Figure 4.1.3 Smokers, ex-smokers and young smokers, New Zealand, 1976-88

4.2 Smoking amongst New Zealand women

Summary

The percentage of young women taking up daily smoking dramatically increased between 1976 and 1988. In 1988, more than half of young New Zealand women (under age 25 years) were or had been regular smokers; over one third are currently smokers. Among youth (ages 15 to 24 years), the percentage of females who smoke any kind of cigarette or tobacco is higher than for males. More women than men in New Zealand smoke manufactured cigarettes.

The lung cancer rate in New Zealand women tripled between 1964 and 1986, and is still rising - steeply. The same high rates of lung cancer are also now seen in a number of countries, where smoking among women has been common for twenty to thirty years (Figure 4.2.1).

Figure 4.2.1 Women, percentage who smoke, and lung cancer death rate in women, selected countries, 1985-86

Of all age groups of women in New Zealand, smoking is now most common in the twenties, the most popular age for childbearing. The high smoking rates in recent years have been associated with the high posmeonatal and cot death rate affecting New Zealand infants (see 2.3.5). Although the percentage of 'ever smokers' who have quit smoking is increasing, new smokers quickly replace smokers who quit.

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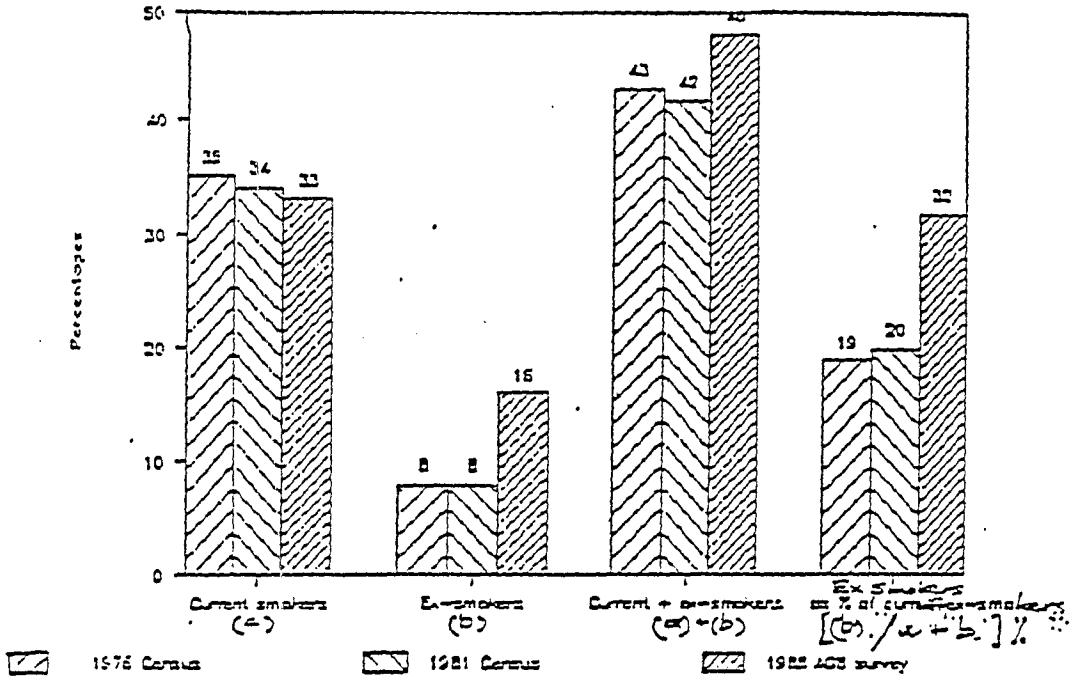
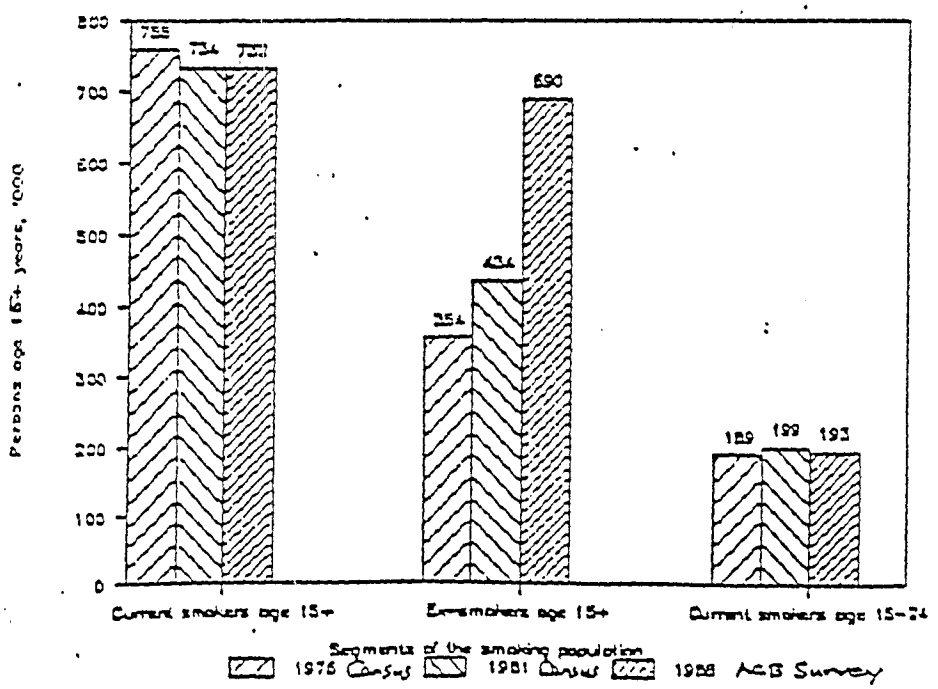
Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000



Note: Hand rolled and manufactured cigarettes included

- Current + ex-smokers = ever smokers = the percentage who have taken up smoking
- Ex-smokers as a percentage of ever smokers = the percentage who have quit smoking

Fig 4.1.3 Smokers, ex-smokers and young smokers, New Zealand, 1976-88



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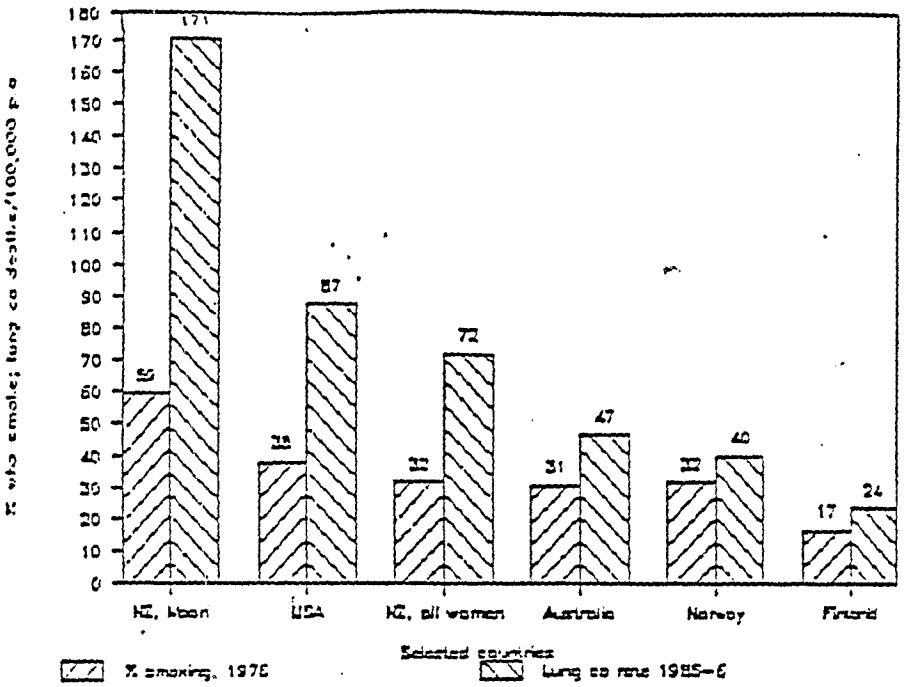
Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000



Source: NZ Department of Health
World Health Organization
World Health Statistics Annual 1987

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Figure 4.2.2 Cigarette smoking uptake, quit rate and smoking prevalence among New Zealand young women ages 15-24, 1976-1988

Lung cancer mortality rates in New Zealand women have tripled since 1964 (Table 4.2.3), the year in which the United States Surgeon General's report publicised smoking as the cause of this disease. Rates are still rising steeply, and the same is true of other countries where women have been smoking in numbers for many years. New Zealand ranks about eleventh highest among all countries for overall women's lung cancer death rates (Table 4.3.1).

Smoking in women is of particular concern because:

- Many women are on oral contraceptives, which in smokers increases the risk of heart attack.
- Women who smoke are at increased risk of cervical cancer.[4]
- Women who smoke have an increased risk of miscarriage and the infant has increased health risks.[5]
- Parents' smoking habits tend to influence the smoking habits of their children.[1]

So why are more and more women smoking? There is not one simple answer, but tobacco manufacturers world-wide, including New Zealand, have paid close attention to gender differences in demand for menthol and mild cigarettes, and have backed this up with cigarette advertising targeted at women(see 6.1). Low coverage of smoking as a health issue has been noted in both American and New Zealand periodicals, including women's magazines (see 6.7).

4.3 Smoking amongst Maori

Summary

Maori people have smoking rates and lung cancer rates approximately twice that of the non-Maori population, and among the highest in the world for any population group.

Maori women have a death rate from lung cancer that is nearly double the highest rate recorded for the female population of any single country in the world (Table 4.3.2). Nearly two Maori women in every 1000 in the age group 55-64 die each year from lung cancer.

The annual rate for cancer of the lung in Maori women in the 55-64 age bracket in 1981-85 was 766 per 100,000, as compared with a rate of 362 for non-Maori women.[6] To cite another figure, the 1981 Census showed that 58.5 percent of Maori women smoked cigarettes daily, as against 33.1 percent for non-Maori women.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

As stated in *Hauora* published in 1988,

> There would seem little doubt that the excessive prevalence of smoking in Maori people, particularly Maori females, is now having a disastrous effect which will increase in the next one to two decades. The implications of this burden in terms of the Maori family and social structure may be far reaching, for Maori women have such an important role, not only in parenting and nurturing but also in the leadership role they play in the Maori community. The high rate of smoking amongst Maori (men as well as women) is an issue not only of health but of equity between Maori and other races. Failure to act rapidly on this issue would mean that new Zealand's commitment to Maori health could not be taken seriously.[7]

Clearly, a number of factors are responsible for the high rates of smoking amongst Maori people. The percentage who smoke is higher in any case among those with fewer years of formal education, and among blue collar occupations, but the percentage of Maori who smoke is still higher after such factors are allowed for. The question of who profits from Maori smoking, and by how much, is relevant to the issue. The Maori segment of the tobacco market is worth $27 million in ex-factory sales to tobacco manufacturers, or 16.3 percent of the 1988 tobacco market. Assuming the average Maori smoker purchases the same number of cigarettes per day as others, then in late 1988 Government was probably receiving $95 million annually in excise and goods and services tax from Maori cigarette smokers, at a rate of $2.14 per packet or 11 cents per cigarette.[8] By April 1989 the tax take per packet had increased by 40 cents. Government health expenditure on education for (specifically) Maori aspects of smoking was under $100,000 in 1988, although population-wide approaches are also intended to assist the Maori smoker.

Reinstatement of the question on smoking status in the 1991 Census is essential for accurately establishing the percentages of smokers among Maori; ordinary surveys do not provide this accuracy, particularly as the Census has the potential to link a smoking question with a question on tribal or iwi affiliation, which means linkage with iwi health and welfare.

The Maori Women's Welfare League, mindful that the Maori people need policies to help create a healthier social environment, supported the Toxic Substances Board call in 1986 for a ban on tobacco advertising.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Table 4.3.1 Cancer of the lung in persons, age specific rates per 100,000 men and women in each age group, for all countries listed, ranked by the rate in the 55-64 age group

Country	Year	Age Group 55-64	
		Males	Females
NZ Maori	1981-85	313.7	171.1
Czechoslovakia	1985	304.6	25.8
Hungary	86	293.0	43.6
Poland	86	286.7	34.0
Luxembourg	86	281.3	17.9
Scotland	86	280.5	120.5
Netherlands	85	246.8	33.5
Italy	83	240.0	22.8
Malta	86	229.2	29.6
England & Wales	85	226.5	81.8
United States	84	220.1	87.0
Denmark	85	210.7	90.0
Canada	85	206.0	74.8
Hong Kong	86	204.3	78.4
Germany DRG	85	193.2	22.0
Ireland	84	191.1	72.1
Finland	86	190.8	24.1
Singapore	86	183.5	52.4
Greece	85	178.7	26.1
Australia	85	177.9	47.1
Switzerland	86	176.5	26.0
Yugoslavia	83	175.4	23.6
Germany FDR	86	175.2	26.0
France	85	171.9	15.2
Uraguay	85	171.6	9.5
Austria	86	169.2	27.6
Bulgaria	85	165.8	23.6
New Zealand	85	163.0	72.5
Argentina	82	148.6	14.2
Iceland	85	131.3	69.3
Spain	81	130.4	12.5
Norway	85	119.1	40.2
Cuba	85	115.8	38.0
Portugal	86	99.5	16.0
Israel	85	88.2	26.4
Sweden	85	85.9	31.8
Chile	84	80.8	21.1
Republic of Korea	85	77.0	15.5
Japan	86	72.7	20.1
Costa Rica	84	62.9	20.6
Kuwait	86	48.8	18.6
Martinique	85	46.7	25.6
Ecuador	84	19.2	7.4
Suriname	85	15.6	0.3

Source: *World health statistics annual 1987.*

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

4 Notes and references

1 Silva, P.A. personal communication 1988, based on a cohort of approximately 900 Dunedin-born young people, interviewed at 9, 11, 13 and 15 years of age, with 95 percent follow-up.

2 OTR Spectrum doorstep surveys of over 10,000 persons annually, analysed from quarterly data by the Department of Health. (This includes smokers of roll-your-own and manufactured cigarettes).

3 OTR Spectrum surveys as cited.

4 *Reducing the health consequences of smoking: 25 years of progress. A report of the Surgeon General, 1989*. U.S. Department of Health and Human Welfare, 1989 at p.57-58.

5 Ibid, at p. 71-3.

6 *World health statistics annual, 1987*

7 Pomare, E. and de Boer, G.M. *Hauora. Maori standards of health: a study of the years 1970-84*. Special Report series 78. Department of Health and Medical Research Council, 1988.

8 Calculations are based on (1) The tax take per 1000 cigarettes, from a memo from Treasury to Department of Health, 29 November 1988 (2) the percentage of the population age 15 and over who are Maori: 7.9 percent in 1987, according to Department of Statistics, mean population estimates (2) The percentage of Maori who smoke cigarettes : 59 percent in 1988 (OTR Spectrum doorstep surveys).

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

PART TWO : TOBACCO PROMOTION AND ITS EFFECTS

5 TOBACCO MARKETING, ADVERTISING AND SPONSORSHIP

Summary

5.1 Marketing methods

The marketing of tobacco products goes far beyond highly visible advertisements in magazines and newspapers, point-of-sale material and sponsorship of sporting and cultural events. The less visible non-advertising methods of marketing play a key role too, and would continue following the elimination of tobacco advertising and promotion. These marketing methods include those which focus on:

- *The tobacco product itself, such as its flavour, aroma, nicotine and tar content, and price*: Over eighty cigarette brands or brand variants were on sale in January 1989, with considerable price variation. Not all of these are advertised.
- *The product's availability and accessibility*: Tobacco products outrank other drugs of addiction not only because they cause more deaths (see 1.3), but also because they are more widely available. The number of tobacco retail outlets is such that the smoker has a relatively short distance to travel to purchase another packet. Retail outlets for tobacco include - dairies (2,300), most petrol stations (1,353), grocers (1,717), supermarkets and takeaway food stores (1,667), tearooms, coffee shops and unlicensed restaurants (1,683), hotels, workplaces and sports clubs - some 13,500 in all.[1] Today, the ratio is approximately one tobacco outlet per 200 persons aged 16 and over. Many of these remain open at weekends.
- *The tobacco retailer*: Through visits of tobacco company staff, the retailer is given incentives to promote new brands.
- *The brandname and the packaging*. Brandnames on packets, reinforced by the brand colours, logo and pack design, are reminders of and links to the images placed in the minds of potential purchasers by tobacco advertising and sponsorship over many years.[2]

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

5.2 Advertising

Less than half of tobacco advertising and sponsorship expenditure takes place through the print media[3] (Table 5.1.). The rest is accounted for by advertising at shops where tobacco is sold, and by sponsorship advertising.

Tobacco advertising in New Zealand is controlled by an agreement between the Minister of Health and the tobacco companies. (For the history of restrictions in New Zealand, see 8.8.) This agreement has been renegotiated every three years or so. The 1987 Agreement expires in December 1990. The Agreement does not permit advertising on radio, television, billboards or the cinema, and it places a number of restrictions on the size of individual advertisements and their content, though not on advertising volume, which has recently increased greatly (Table 5.2.). The manufacturers' view was that 1987 was an unusually low year for advertising due to the change of ownership of Rothmans, and that 1988 was an abnormally high-expenditure year due to the launch of 20 new brand variants, and the purchase of 17 percent extra space to accommodate the larger disease warning, and at the same time, maintain the same size of brandname advertising space as before.[4]

In New Zealand, tobacco product advertising and promotion is almost entirely carried out by or for the two leading tobacco manufacturers, Rothmans and Wills, and by one cigar manufacturer, the Continental Cigar Company in Auckland.

These companies advertise their products through several media and in a number of ways, notably,

- *The launching of new tobacco products*: The huge increases in smoking that occurred during the 1960s and early 1970s were fostered by a segmentation of the market. Plain gave way to filter tip, short gave way to king size. A profusion of brands were launched, for example, up-market and down-market, high tar then low tar, strong then mild and menthol. The market remains very active, with at least 20 product variants launched during 1988, and more in 1989.

- *Marketing campaigns*: These employ a coordinated marketing mix comprising press and magazine advertising, sponsorship, and liaison with retailers, whereby tobacco representatives visit shops to supply and place point-of-sale material.

- *Point of sale advertising:* This includes wall and window posters at the 12,000 tobacco outlets. The tobacco manufacturers employ or contract workers to visit shops in rotation and erect advertising signs and redecorate windows with new tobacco advertisements. The focus of point-of-sale advertising tends to be the sales counter. Counter displays facilitate repeat purchases and the sampling or purchase of new brands by smokers.

  The total number of cigarette advertising signs in New Zealand probably exceeds 50,000. In 1986, dairies carried an average of eleven tobacco advertisements each, six outside and five inside.[5] As most children pass at least one dairy per day, their exposure to this form of advertising is probably greater than their exposure to newspaper advertising. Children

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

say that cigarette advertising in dairies is 'all over the place', and 'couldn't be missed'.[6]

Table 5.2. Annual expenditure on mass media advertising by manufacturers for cigarettes, and by health agencies against smoking, 1973-88, in thousands of 1988 NZ dollars

Year	For cigarettes	Anti-smoking
1973	4,809	0
1974	3,824	0
1975	3,990	0
1976	4,811	0
1977	6,582	0
1978	5,995	0
1979	4,063	54
1980	4,021	0
1981	3,701	0
1982	4,301	0
1983	3,875	0
1984	4,548	42
1985	3,261	86
1986	2,609	358
1987	2,924	0
1988	4,676	74

Note: Production costs are not included.
In the absence of an advertising price index, the expenditures have been deflated by the Consumers Price Index. Expenditure is estimated by rate card method. Cigarette advertising expenditure recorded here is for press and magazines only, and does not include shop advertising posters and signs, nor sponsorship. Cigarette print advertising represented 99.1 percent of all tobacco print advertising in 1988. The health advertising here is mainly for television and radio, and does not include printing of posters and 'No Smoking' signs.

Source: Press Research Bureau and Hunter AGB data purchased by Department of Health

- *Advertising in magazines:* Approximately 2000 cigarette advertisements were placed in magazines and newspapers in 1985, at an average rate card value of around $1,180 each.[7] (Rate card value is the advertised rental value for each time an advertisement is placed.)
Magazine advertising permits full colour and the targeting of certain age, gender, income and special interest groups. The magazines used include many with a high teenage readership,[8] including New Zealand Listener, the New Zealand Women's Weekly, and More.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

- *Tobacco advertising in newspapers:* Newspapers permit frequent advertising during the launch of a new tobacco brand, allows a manufacturer to increase the advertising quickly once a brand launch begins to succeed, enable rapid counter-advertising against a rival manufacturer's brand, and gives the manufacturer wide and repeated access to the public, to keep awareness of the advertised brand high among smokers. The *New Zealand Herald*, the newspaper with the largest circulation in New Zealand, in 1986 accepted tobacco advertising worth over $500,000, and in 1988, 0.9 million[9] (see 6.7).

5.3 Sponsorship

It was explained to the Subcommittee that sponsorship is a method for increasing awareness of a brandname in the public mind, and that dollar for dollar it has certain advantages over other advertising methods. A typical contract signed by a tobacco manufacturer includes increased brand awareness as one of the purposes or expected results. A Royal Commission has ruled, 'Sponsorship in all its forms is a mode of advertising'.[10] Tobacco advertising by sponsorship links the tobacco brandname with healthy (example, cricket), exciting (motorsport), or prestigious (theatre, fashion) activities, and the brand image is matched to and reinforced by the activity, for example, the Dunhill ambience for the theatre, Winfield for softball.

Sponsorship is a form of corporate advertising but with respect to tobacco, brandname advertising dominates. A range of tobacco brandnames are advertised, and corporate it might be called, for a company can be formed if necessary for each brandname. Wills is a corporate name but is only advertised on New Zealand television when cricket from Pakistan is shown - Wills is a brandname there. Rothmans is advertised, but so are other brandnames marketed by Rothmans.

The Subcommittee was informed that tobacco sponsorship probably provided not much more than about $1 million out of the national total of some $50 million sports sponsorships and $15 to $20 million arts and culture sponsorships. The tobacco contribution is thus of the order of 1.5 percent of the total.

In 1986, 20 percent of all sport listed for television (apart from sports segment of the evening news) was tobacco-sponsored and therefore showed tobacco brandname advertising. In the summer quarter, tobacco made up over half of all televised sport. Of all televised tobacco sponsorship activities, 87 percent was cricket, 12 percent tennis. Of the 182 hours screened, 70 percent was filmed in New Zealand, the remainder from overseas events. Of all sport televised within New Zealand, tobacco sponsorship made up 40 percent of the hours listed.[11]

Consequently, although tobacco sponsorship is a very small proportion of total sponsorship funding, it is able to achieve salience by funding a few large sponsorships of sport which will attract television audiences. With the remainder of their sponsorship budget, tobacco manufacturers have sponsored to a lesser degree, a wide range of sports and cultural events in recent years, as the submissions testify.(Appendix 6).

The number of viewing hours devoted to television coverage of tobacco-sponsored sport, in particular tennis and cricket, has increased tenfold since the

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

1970s, and quadrupled between 1980 and 1986. The tobacco sponsorship contract ensures the placement of tobacco advertising signs (each carrying a cigarette brand name) on ground perimeters at sporting venues. These signs, it appears, are judiciously placed with likely television camera angles partly in mind. Cultural events include the annual Benson and Hedges Fashion Awards, which appeals to women, and presumably to young women.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

The number of times the sponsor's brandname is seen on television is evaluated through monitoring television, by the firms which specialise in sign placement. Information on the likely age and gender composition of the television viewing audience can be purchased from a media research firm. If the results are not favourable in terms of brand awareness and other factors, the sponsor can then decide not to renew the contract.

Furthermore, television has, at least since 1987, has accepted payment for prominent trailer advertisements which introduce tobacco-sponsored events. The tobacco brandname is advertised in this way, and the event becomes known by the brandname. (Approximately $190,000 of advertising in rate card value was placed on television for the 1987 cricket season).[12] In 1988 a similar sum was paid - presumably by the New Zealand Cricket Council, as the 1987 Agreement prevents tobacco manufacturers from paying for such advertisements. The substantial sums spent by tobacco companies on such coverage indicates its importance to them. The agreement on tobacco advertising between manufacturers and the Government permits this practice.

To the tobacco industry, then, sponsorship does not mean an anonymous charitable donation. Some sponsorships merely underwrite the costs of staging the event. Other contracts are organised by tobacco companies directly with the sports organisation, or by a professional sponsorship broker. The sports organisation receives help to stage the event, and may keep part of the gate money, but will not necessarily receive any grant.

Lower levels of sport, minor sports, losing teams (and sport which does not make good television) tend to attract less interest from sponsors. A wide range of sporting organisations, big and small, however, have been assisted by tobacco firms, as have other organisations. (Many made submissions - see Appendix 6). Other organisations, again both big and small, including the 1990 Commonwealth Games Committee in Auckland, have refused on principle to be associated with tobacco.

In summary, tobacco product advertising was banned from television screens in 1963 by the broadcasting authorities, and the 1987 Agreement between the Government and tobacco companies does not allow tobacco product advertising at sponsored events (except at a shop where cigarettes are sold). Advertisements around the sports arena cannot depict or mention cigarettes, but cigarette or tobacco brandnames are permitted. Thus, the advertising of tobacco products is technically avoided; and the promotion of tobacco brandnames on television continues (see also 6.5 and 12.1).

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Notes and references

1 Based on Census of distribution, *New Zealand Official Yearbook*, 1980.

2 Carr-Gregg M. *Tobacco Imaging* Submission from the Coalition to ban tobacco advertising and sponsorship, to the Board April 1989.

3 Based on information from the tobacco manufacturers on their advertising in recent years.

4 Interim submission of the Tobacco Institute of New Zealand to the Toxic Substances Board Tobacco Subcommittee, 5 April 1989, p.6.

5 Survey by Consumers Institute of forty shops in four main centres, March 1986.

6 McClellan, V. *A national survey of the smoking habits of form one students in New Zealand schools*. Health Services Research and Development Unit, Department of Health, 1987, p. 33.

7 Cost per advertisement was estimated in current dollars by the aPress Research Bureau.

8 High teenage readership here refers to numbers of teenagers exposed to the advertising and not to percentage of the total readership. The Tobacco Institute have pointed out that in readership surveys the definition of a reader is rather minimal.

9 Press Research Bureau data, 1986, and Hunter AGB data, 1988.

10 *Broadcasting and related telecommunications in New Zealand: Report of the Royal Commission of Inquiry*. September 1986.

11 Department of Health count of programme listings in *the New Zealand Listener*.

12 Letter from Television New Zealand to Tobacco Advisory Council Official Information request, 28 April 1987.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

6. TOBACCO ADVERTISING AND PROMOTION - ITS EFFECTS

Summary

This chapter addresses the question, - 'Does tobacco advertising increase total sales of tobacco - a market *size* effect - or merely affect the market *share* of advertised brands?'

After reviewing fourteen countrywide studies of tobacco advertising, income, price and sales, and the written and oral submissions of the parties concerned, the Board concluded that advertising increases total cigarette sales. This effect assumes no change in the other measurable factors that are known to influence tobacco consumption, namely, per capita income and tobacco price relative to the price of other goods. On the basis of two New Zealand studies, a total advertising ban, other factors being equal, has the effect of lowering tobacco consumption in New Zealand an estimated 7 percent below what it otherwise would have been in the absence of a total ban. This effect on tobacco consumption should save lives, over and above any future effects of such an advertising ban on the percentage of young people who smoke.

The Board in reaching this conclusion, rejects the tobacco manufacturers and the advertising associations' view that tobacco advertising only promotes brand-switching and does not increase total sales.

6.1 Viewpoints - the other side of the denial coin
6.2 Econometric studies
6.3 The relationship between advertising, smoking and ill-health
6.4 The effects of advertising on young people
6.5 Tobacco sponsorship advertising effects
6.6 The brand-switching argument
6.7 Indirect effects of cigarette advertising on coverage of smoking issues

6.1 Viewpoints - the other side of the denial coin

The reinforcing role of tobacco advertising in keeping smokers smoking (smoking the advertised brands) has been acknowledged by New Zealand's major tobacco manufacturer, for example, when speaking of brand-switching and old customers: 'That new customer's choice has to be supported, along with those smokers who already enjoy our products'.[1]

Despite even franker statements by some of their own tobacco and advertising executives to the contrary,[2] the tobacco and advertising industries worldwide officially deny that tobacco advertising increases total tobacco sales.

Questions regarding the actions of the tobacco industry world-wide give a different perspective to this denial (see 6.1.1.), as do more empirical arguments based on sophisticated statistical methods. (see 6.2)

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

6.1.1 Questions regarding tobacco industry advertising practices

o Why do monopolies advertise?

Tobacco monopolies, often State-owned, exist in a number of countries, and many of them advertise, even when they control more than 90 percent of the market. If monopolies advertise then it must be to expand market size (total industry sales).

Table 6.1.1 Tobacco advertising expenditures by monopolies, press and magazines only, Western Europe 1979

Country	Advertising per country in millions 1979 $US	Advertising per capita as % of 1980 US$	Local production market share
Denmark	2.65	1.41	86.7
Austria	0.52	0.20	94.9
Spain	0.76	0.06	91.1

Note: In New Zealand, in 1979, cigarette advertising in press and magazines in $1988 was US $0.52 per capita (Press Research Bureau). The monopolies in France and Sweden also advertised, but had only 79 and 80 percent of the market.

Sources: Tucker Tobacco, An International Perspective, Euromonitor Publications: 1982, Table 32, p. 204
Tobacco Quarterly, 1979 official yearbooks.

Why spend so much?

In the United States in 1987 manufacturers spent $1.6 billion on advertising tobacco.[3] It is inconceivable that promotion on this scale has no effect on total sales. Commonsense suggests that tobacco companies promote their products because it pays them to do so. It seems reasonable to assume that tobacco manufacturers behave with commercial rationality.

Commonsense (and empirical evidence)[4] would also argue, that when soap manufacturers promote many different brands of soap, they also promote overall soap sales - and cleanliness. A corollary, then, suggests that when tobacco manufacturers advertise and promote many brands of tobacco for smoking, overall tobacco sales are also promoted.

Why use themes of universal appeal?

The argument that advertising affects brandshare only is a reasonable one when applied to a limited and defined market, such as motor oil for cars, but when addictive tobacco products are advertised to all, using themes of near universal

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addictive tobacco products are advertised to all, using themes of near universal appeal, the possibility or the purpose of that advertising could well be an increase in market size.

The 1987 New Zealand Code for the marketing of tobacco products denies that promotion is aimed at increasing market size. When the manufacturers signed the Agreement, they agreed to this wording:

> 'Tobacco product advertising and marketing will not be directed towards increasing the number of smokers, or increasing the consumption rates of existing smokers, and be intended to effect a change in brand.'[5]

Although tobacco trans-nationals have promoted such industry-government codes on advertising in a number of countries, the local tobacco manufacturers face an impossible task in attempting to comply with such a wording.

A cigarette advertisement must only be seen by smokers, even when it is placed a in popular family magazine such as *The New Zealand Listener*, which has a readership made up overwhelmingly, of non-smokers. To non-smokers, ex-smokers and would-be smokers, the advertisement must be invisible. If it is unwittingly sighted by these others, it must still influence only smokers; and influence them only to switch brands, not to increase consumption. Also the tobacco advertisement is expected to depict situations where cigarettes are smoked, but without cueing the ex-smoker to reach for a cigarette. While portraying smoking as 'cool', adult-only behaviour, it must not encourage experimental under-age smokers, even if they want to show how grown-up they are.

Although the agreement is, as noted, *not* to increase consumption, the visual images used appear to be designed to *increase* consumption. Cigarettes are not only shown, but shown protruding invitingly from the pack, being offered or displayed, or being received. The 'Go For It' captioning on *Peter Jackson* 30s advertisements is straight-out encouragement to smoke, in current youth idiom.

The themes in cigarette advertisements are themes that appeal to most people, not just smokers. Analysis of some of the themes in recent tobacco advertising, show them to have wide or universal appeal:

> *Escapism* and dream wishes lie behind the 1987 'Let's..' (*put the statue of Liberty in our back garden*)'..what a Sterling idea' series.
>
> Both feminist and feminine values are used in advertising cigarettes for women. The appeal is to all women and any woman. With the *Sterling* 'family of milds', each pack is held by a woman's hand, and displays a full selection of different tar levels, tobacco flavours or menthol to suit every woman's taste. *Vogue superslims*, promoted from January 1989, are advertised in soft pastel colours, and captioned to appeal to all the senses - 'see.. feel.. taste.. the difference'.
>
> *Female emancipation* is suggested by the '*Let's invite the guys over and play pool*' (*Sterling* 1987) and, more explicitly, by the *Topaz* caption '*Get the wild taste of freedom*', used before content was controlled more closely in the 1979 New Zealand agreement. *Equality* with men was also

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portrayed in the *Topaz* advertisements of the late 1970s, with such images as women smokers changing a tyre.

Value for money features in many advertisements, for example, *'Rothmans - the best tobacco money can buy'* and the 1989 advertisement for *Pacific*, which emphasises this brand's lower price.

Appeals to success are perhaps hinted at in the *Winfield* advertisement showing only the first three and a half letters of the *Winfield* brandname.

High status, imagery and luxury (for example, a table with gold embossing on leather inlay) is the appeal used by up-market brands to maintain their market image (*Dunhill International* 1985, *Dunhill Deluxe* 25s, 1989). The *Rothmans* advertisement uses the status of the airline pilot to proffer a packet of cigarettes.

Perhaps to help distract from the health warning, flippant or nonsense copy with an umbrella sketched over the cigarette packet is used in the *Peter Jackson* 1989 advertisements. The near universal value placed on a healthy outdoor life is capitalised on by a brandname such as *Sportsman*, and by activities such as yachting (*Peter Stuyvesant*), or by association through sponsorship with cricket (*Rothmans, Benson and Hedges*).

Lethal to sell, yet legal to advertise?

The 'legal to sell, legal to advertise' principle was mentioned by a number of groups who met the Board's Tobacco Subcommittee. In response to the concerns of some groups, the Subcommittee made it clear that it viewed tobacco differently from alcohol, in that tobacco use in low doses markedly increases mortality risks, while abuse or misuse of alcohol is generally necessary to achieve a fatal result from alcohol. In view of the proven harm from tobacco products, the Board rejects the implication of quoting this principle with respect to any tobacco product, that legality to sell implies right to promote.

The Heylen Institute, acting, for the Tobacco Institute, surveyed 1000 adults in September 1988 and found that 68 percent of those surveyed agreed with the proposition 'If it is legal to sell a product, it should be legal to advertise it, subject to normal advertising industry restrictions.'[6] *Even if the product kills 4000 users of the product each year?* If a question offering this sort of clarification had been added, the answer would almost certainly have been quite different, as the result of a 1987 New Zealand-wide survey of support or non-support for a tobacco advertising ban indicates (65 percent agreed that tobacco advertising should be banned - see 10.1).

Freedom is seldom absolute and, once harm was proven and publicised, the freedom of tobacco manufacturers to advertise their legal product began to be restricted in New Zealand, beginning with a broadcast ban in 1963.

'Legal to sell, legal to advertise,' while a useful rule of thumb for most products, has, for tobacco, been challenged for several decades by New Zealand legislators. Furthermore, legality to sell a toxic product is not a right, but is governed by the Toxic Substances Act, 1979. The Act was amended in 1986 to prohibit the sale of tobacco for oral use, and again in 1988 to prohibit sale to persons under 16 years. Other countries have recently passed similar restrictions.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Nor is the right to advertise absolute. Since new knowledge of the health consequences of tobacco was first widely publicised in 1964, the governments of almost all developed countries, and many in the developing world have accepted the need to make tobacco advertising illegal in at least some media.

Where rights conflict a decision has to be made. The freedom of thousands of young people to be free from pressure to smoke harmful tobacco products would seem to be more important than the right of manufacturers to promote such products. As the title of this Report implies, the choice is health *or* tobacco.

6.1.2 The withholding of information by the tobacco industry

Few independent researchers in any country have had access to the advertising and sales-in-response-to-advertising data available to tobacco manufacturers.

Data on total tobacco promotion expenditures, for example, are impossible to obtain in most countries. In Britain the tobacco industry will only issue its data from analysis, if it can retain a right of veto right over publication.[7] In New Zealand the Board requested data for econometric analysis from the industry and was provided data, on a confidential basis, for four quarters and one year, insufficient for statistical analysis. This is no substitute for research by independent researchers based on complete data available in the public domain.

If the industry case is robust, such an analysis should enable its case to stand firm and even be strengthened. In the scientific community withholding of important data, which inevitably stifles research and discussion, is regarded as a serious matter. Certainly tobacco industry data are there. Over the years, major tobacco manufacturers, in their company financial records, and in their reports to the offices of their controlling companies overseas, have compiled monthly, quarterly and yearly advertising expenditures and tobacco firms collect sales and stock data weekly or monthly from retailers and wholesalers on all brands sold, not just their own brands.

To take the argument further, tobacco advertising in New Zealand is opposed by all major health agencies for its role in promoting smoking, yet *informed* public debate is not helped by the fact that apart from the independent commercial monitoring of press, magazine and television advertising, the extent of tobacco advertising and promotion expenditures cannot be brought into the public domain. Nor has the Toxic Substances Board the legislated power to requisition such data, as has the Federal Trade Commission in the United States.

Commercial sensitivity is understandably pleaded from the industry side; manufacturers do not want their data released to each other. But it is difficult to understand how commercial sensitivity applies to data of previous years, and particularly to data of previous decades. While each firm is well aware of its own expenditure, this reticence on the part of the tobacco industry suggests that the industry does not have open access to an accurate estimate of its own advertising expenditure. Without knowledge of the total industry expenditure, how can the industry have the necessary econometric analyses carried out to disprove that advertising raises consumption? Another scenario is that in some countries the analyses have been done, but that the industry, knowing the findings, has decided not to publish them.

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6.1.3 Advertising - slowing the decline

The Tobacco Institute in oral and written submissions to the Toxic Substances Board has argued that advertising cigarettes in New Zealand cannot be blamed for the present levels of consumption because the numbers of cigarettes sold have been falling for many years.[8]

This objection is easily dealt with:

(1) Advertising raises consumption, but the correct sense of this statement must be explained.

(2) As known from econometric studies, and as explained in the New Zealand section of 6.2 below, *other factors being equal,* advertising raises consumption *above what it would have been without the advertising*.

(3) This means that when consumption is in a decline and is expected to fall further in a coming year for other reasons, (public awareness of the health risks, tobacco taxation, fall in personal incomes), then, these other factors remaining equal, tobacco advertising will slow the expected decline in consumption.

(4) Conversely, tobacco consumption will decline more rapidly if tobacco promotion ceases (as shown in section 7.5.1).

Tobacco consumption per adult has been falling in New Zealand (since 1963) and in most other Organisation for Economic Cooperation and Development (OECD) countries as

- the health consequences of smoking have become better understood
- prices have risen
- advertising has been restricted.

But the rate of the decline is slow. Although some of the slowness of the decline is attributable to rising incomes, New Zealand has taken a quarter of a century to achieve a one-third fall in consumption, and these questions must be asked:

- Could this decrease have been more rapid?
- Have the millions that have been spent in promoting tobacco slowed the decline in consumption?

As this report shows, the answer to both questions is yes. With regard to the first question, as Chapter 7 implies, the decrease could have been more rapid if, along with other measures to control tobacco consumption, tobacco promotion and advertising had been curbed in all media earlier.

The second question is inevitably bound up with the first. Tobacco advertising and promotion have, as the following brief description of post-World War II smoking trends and the review of the literature (6.2) demonstrate, been instrumental in, first, widely popularising smoking and, second, counteracting those influences which reduce consumption, such as higher taxation on tobacco products and public concern over the health hazards of smoking.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

World War II further popularised cigarettes among men and, more particularly, among women. In competing for post-war market share, tobacco manufacturers modified their product and increased their advertising. In place of the strong male-smoked tobaccos in handrolled and handmade cigarettes, manufactured cigarettes containing milder blends of tobaccos were promoted. In country after country, advertising facilitated a shift from handmade or handrolled cigarettes to plain manufactured cigarettes. When the first lung cancer evidence was published widely in 1952, cigarette advertising in the United States was not decreased; instead, as a percentage of sales it was doubled.[9] In New Zealand the *Benson and Hedges* launch in about 1966, two years after the U.S.Surgeon General reported that smoking caused lung cancer, cost, in 1988 dollars, $10 million or over $5 per adult. Later, in response to health concerns, advertising sought to promote filtered then mentholated cigarettes[10] and, later, low tar cigarettes.

In New Zealand, around 1960, just when male tobacco smoking was declining due to health concerns, product innovation in the form of the king size filter cigarette (Rothmans[11] and other brands), backed by advertising, allayed smokers' fears and fuelled an upward swing in cigarette consumption until 1975. Heavy promotion associated with new mild or low tar brands around 1977 was associated with another peak of consumption in that year. Mild or low tar cigarette brand shares rose from 2 percent to 12 percent in the 1977-80 period.[12] From 1977 to 1987 tobacco advertising in print media fell and so did consumption.[13] Most recently in 1988, increased advertising has been associated with delayed falls in smoking among young people.

6.2 Econometric studies of tobacco advertising

6.2.1 Strengths and limitations of econometrics

Econometrics is a means of analysis which uses economics, mathematics, and statistical techniques such as multiple regression, a method for distinguishing among competing and simultaneous influences on an end result, in this case, tobacco consumption. Here, multiple regression can hold other factors, such as price and income, constant, while focusing on the effect of advertising on consumption.

- Econometrics does, however, have limitations for study of the effect of advertising on tobacco consumption:

- The effects of advertising on subsections of the population cannot easily be measured, since tobacco consumption is only measured for the whole adult population. Some subsections may be particularly susceptible to advertising.[14]

- No allowance is made for the turnover of smokers and for the rate at which young smokers replace those quitting or dying. In the Unites States, 5 percent of adult smokers quit or die each year (of diseases related or unrelated to smoking).[15] Where advertising encourages young people to replace the sick or quitting smokers, thereby keeping tobacco consumption at a standard level, econometrically no effect can be shown.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

- Econometricians need to be able to assign numerical values to all the important influences before analysis commences. Factors such as the tobacco factory production manager's ability to blend a tobacco that will appeal to smokers and potential smokers, and the skill of the advertising agency to write and design effective advertising, will affect the sales response to some brand launches. Because such factors are difficult to quantify, they are usually omitted from econometric analyses.

6.2.2 Econometric studies reviewed

Fourteen studies were located which analysed advertising, tobacco price and personal income against national industry-wide sales of cigarettes (Table 6.2.2).

Eleven of the fourteen studies showed that advertising significantly affected national cigarette sales. Most of these eleven studies were published in refereed economic journals rather than in health or medical journals.

Three studies failed to show any effect: two used insufficient observations and were based on annual data;[16,17] the data from the remaining tobacco industry commissioned study[18] have never been released (See below under the United Kingdom). None of these three studies was published in an economics journal.

Take in Table 6.2.2 in about here

The quality of the fourteen studies varies greatly. In assessing their reliability and validity, the following need to be kept in mind:

A Studies based on few and infrequent observations should be accorded less importance

- A large number of observations are needed, at least thirty, and ideally over 100. Yearly studies with few observations tend to generate false negative results. Schmalensee used twelve annual observations and, not surprisingly, found no effect on sales from advertising, price or income. He noted the difficulty of trying to estimate advertising effects using annual data.[19] In contrast, Meads used 168 monthly observations and was able to show that advertising affects sales.[20]

- Frequent observations are needed for the reliable detection of advertising effects. Cigarettes are purchased every few days, whereas newspaper advertisements are read one day and discarded the next, and magazines after a month or so. Data therefore need to be more frequent than quarterly to shed light on the effect on sales.[21]

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Table 6.2.2 Econometric studies on the effect of tobacco advertising on total sales

Author	Period	% Effect on sales of a 10% lift in advertising	Observations Frequency	No.	Variables surveyed
United States					
Comanor, Wilson	1948-64	+5.75	annual	17	A,P,I
Hamilton	1926-70	+2 to +4	yearly	45	A,P,I,H
Fujii	1929-73	0.7	yearly	45	A,P,I,H
Schmalensee	57-68	ns	yearly	12	A,P,I,H
Roberts & Samuelson	1971-82	positive	yearly	12	A,P,I, tar
United Kingdom					
Witt & Pass	55-75	0.7	yearly	21	A,P,I,H
McGuiness	1957-62	+2.8	quarterly	48	$A^{P,tv}$, & P,I,H
Cowling	1962-68	+2.0			
Johnson J	1957-62	+0.9	quarterly	48	$A^{P,tv}$, P,I,H
Metra	1957-78	ns	quarterly	48	$A^{P,tv}$, po, P,I
Radfar	1965-80	+0.3 to 0.9	quarterly	61	$A^{P,tv}$ P,I,H
West Germany					
Leeflang & Reuijil	1960-75	+3.5	annual	16	$A^{P,tv}$,P,I pipe, tar cigars
	1961-65	+1,6	bimonthly	60	
	1971-75	+1.4	monthly	120	
Australia					
Johnson	1962-83	ns	yearly	22	$A^{P,tv}$ P,I
New Zealand					
Chetwynd	1973-85	ns	yearly	13	A^{P} P, I
et al.	1973-85	+0.7	quarterly	52	A^{P} P, I
Meads & Evans	1973-86	+0.7	monthly	168	A^{P} P,I, Sp^{tv}

Key		
	A	total advertising expenditure
	A^{P}	print advertising
	A^{tv}	television advertising expenditure
	H	anti-smoking health scare publicity
	I	Income per capita
	P	cigarette price
	Sp^{tv}	tobacco sponsored hours on television
	ns	no significant effect found
	na	data not available
Sources		See references for this chapter

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

B Some studies leave out important variables

The Metra study did not allow for the effect of the 1971 Royal College of Physicians' report *Smoking or Health*, even though sales dipped in that year.[22] Metra did not include sponsorship advertising but, as an industry study, it should have had access to these data.

The two New Zealand studies did not incorporate health advertising, but the amounts of such advertising were small, infrequent, and less than one fortieth of the tobacco advertising expenditure..

C Studies have to be open to verification

To its credit the West German tobacco industry allowed publication of Leeflang and Reuijil's study[23], whereas the British tobacco industry did not allow independent release of the Metra data.[24] Metra's findings are at variance with those of two independent researchers, and as the Metra data cannot be checked, they are suspect.[25]

D Allowance should be made for possible reverse effects of sales on advertising

Tobacco advertising budgets are usually set as a fixed percentage of sales, which can make it seem as if advertising and sales are somehow related. To exclude this effect, most studies rely on demonstrating that advertising affects sales in a later period. Several studies go one step further and report having explicitly checked for a reverse effect, using simultaneous equations, before claiming an effect for tobacco advertising on sales.[26] Reverse effects have been allowed for in the two New Zealand studies.

E There are good reasons for some studies to show no effect of advertising on sales

- Advertising does not have to be uniformly effective in all market segments to affect market growth. Advertising high tar cigarettes, for example, does not increase the total market, whereas advertising low tar cigarettes increases the total sale of both types.[27]

- Advertising should not be expected to increase total sales at all times. Occasional advertising flops should be expected. The disastrous tobacco substitute brand launches in 1977 in the United Kingdom were costly, and sales did not rise in response.[28] These unpredicted bad results have not dissuaded tobacco manufacturers from advertising; apparently advertising generates enough sales overall to offset such losses.

- Advertising does not have to be economic in the sense of showing improved sales, if the purpose is defensive. Advertising to gain, secure and guard market share requires advertising to emphasise product differentiation. This may require expenditure over and above that required to secure a rise in total industry sales. This being the case, that some econometric studies are able to show statistically significant correlations can be interpreted as evidence that advertising does indeed increase total consumption.[29]

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

- As the product is addictive (see 1.3) and brand loyalty is high, estimated at 80 percent,[30] the manufacturer can afford to wait beyond the financial year for the full benefit to revenue and profit from advertising.[31] This in turn complicates econometric estimations.

G Undue conclusions should not be drawn from studies of the television advertising ban in the United States in 1971

When cigarette advertising on television was banned in the United States from January 1971, cigarette consumption actually increased. Studies of this period have been interpreted as showing that (1)advertising has no effect and (2) bans do not work.[32] This, however, was no ordinary ban. Along with the ban on cigarette advertising, public service anti-smoking advertisements, required by law to balance the tobacco advertising, and which ran in the ratio of about one to every three cigarette advertisements, were also cut, by 80 percent.[33] The fall in consumption while the anti-smoking advertisements were run, the willingness of the industry to agree voluntarily to a broadcast ban, and the failure of consumption to fall after the 1971 ban, all point not to the ineffectiveness of cigarette advertising, but rather to anti-smoking advertisements with more credibility and impact than the cigarette advertisements. Also, from 1971 the industry switched its tobacco advertising expenditures from the banned broadcast media to other media, so that any decrease in tobacco advertising due to the ban was minimised.

Of the fourteen econometric studies reviewed, those which stand up against the above criteria gave the same answer: tobacco advertising tends to increase tobacco consumption and market size, and not just market share.

In some countries it appears that lack of free access to industry data has meant either no data were obtained and no studies carried out, or inadequate data were obtained, making it more difficult to demonstrate any advertising effects on consumption. Where studies show no effect, the tobacco industry, in lobbying against bans, may interpret such studies as having proven that 'advertising does not increase consumption,' when in fact 'not proven that advertising increases consumption' would be more accurate.

Commenting on studies which show that advertising increases total sales, a Tobacco Institute's consultant said the effect was miniscule.[34] Small in percentage terms, perhaps, but not in commercial (or public health) terms. According to the published estimates, a 10 percent change in advertising can mean a billion more cigarettes sold annually in the United Kingdom, as noted below. In addition, manufacturers can increase their advertising budgets by not 10 percent but 60 percent in one year.[35]

In the face of increased health awareness, the tobacco manufacturer today is selling fewer cigarettes per advertising dollar than before the health scares of the 1960s and 1970s.[36] Advertising, however, retains a crucially important influence in certain market growth segments, such as the young, certain ethnic groups and females.[37]

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

From the United States

In the United States national advertising and sales data have been published since the 1920s,[38] permitting a number of American studies on the effects of tobacco advertising on sales. These are reviewed here.

An early study (1942) found that in the period between the two world wars, cigarette smoking increased for sociological reasons, and that advertising acted as an accelerant: 'Without advertising, cigarette use would probably have grown; with advertising the increase has been amazing'.[39]

A study conducted thirty years later of nationwide advertising expenditures and sales for forty one product types of consumables for the years 1948 to 1964 drew the same conclusion as the 1942 study. Advertising, the study found, increased total sales of cigarettes and cigars no differently from the way it increased sales of other non-durable consumables. Total sales, not just sales of some brands, were increased by advertising.

Conversely, decreased advertising results in decreased total sales. This was the conclusion of a study conducted Harvard University staff, and its findings were presented to the American Marketing Association's 1973 conference in Washington DC. The consumables studied included confectionery, cigars, cigarettes, dairy products, soft drinks, soaps, sugar, meat, wines and periodicals.[40]

A particular finding of the study was that advertising was influential in deciding how the consumer spent his or her dollar, whether on tobacco or non-tobacco goods. This influence of advertising on consumer expenditure across a wide spectrum of products and industries confirmed earlier research.[41]

Firms it was noted, usually set their advertising budgets in terms of advertising as a percentage of sales or turnover. Measured in this commercially realistic way, advertising was found to be a more powerful sales determinant than price.[42]

Three other studies examining the connection between tobacco advertising and tobacco sales confirmed the findings of the studies just reviewed. The first of these later studies reported that, from 1950 to 1970 in the United States, advertising ranked third after income and health concerns, and ahead of price, as a leading factor affecting cigarette sales. Over those two decades, cigarettes could be advertised in any medium, and the number of cigarettes smoked per year in the United States increased by 95 cigarettes per adult per year. Indeed, if it had not been for anti-smoking publicity over the two decades, advertising would have raised consumption by nearly 2000 cigarettes per adult per annum.[43]

The second study, a 1980 look at factors influencing demand for cigarettes for the years 1929 to 1973 in the United States, found strong advertising effects on national cigarette consumption.[44]

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

The third study, a 1985 review of the evidence on the relationship between cigarette advertising and smoking, offered the same conclusions as the previous studies, but also highlighted this finding: the televised advertising of little cigars which followed the January 1971 ban on cigarette advertising on television had a considerable effect on little cigar sales, with consumption increasing 290 percent[45] before the advertising of this product (see Fig 6.2.) also was banned in September 1973 by the Little Cigar Act.[46]

Figure 6.2 Sales of Little Cigars in the United States 1965-85.

A more recent (mid-1988) study analysed annual advertising and sales data of the six American domestic tobacco manufacturers, for the years 1971-1982. The data were obtained from economic analysts and media research firms, and researchers drew these conclusions from their findings:

> The results indicate that firm(s)' advertising primarily affects the level of market demand, (that is total cigarette sales) with a firm's effect on rival firms' market shares arising through variations in the number of brands sold. Advertising by any firm may increase total market demand. Low tar advertising has a positive and statistically significant effect on market demand in both the low-and-high tar markets. This suggests that advertising for low-tar products, possibly because of the audience toward which it is directed, increases the demand for cigarettes in general.[47]

Advertising of high tar (older) brands was found not to affect total consumption significantly.

To date not one of the Surgeon General's reports has dealt with tobacco advertising in detail. The 1989 report concludes it section on the subject:[48]

> There is no scientifically rigorous study available to the public that provides a definitive answer to the basic question of whether advertising and promotion increase the level of tobacco consumption. Given the complexity of the issue, none is likely to be forthcoming in the forseeable future. The most comprehensive review of both the direct and indirect mechanisms concluded that *the collective empirical, experiential, and logical evidence makes it more likely than not that advertising and promotional activities do stimulate cigarette consumption*...The extent of influence of advertising and promotion on consumption is unknown and possibly unknowable.[49]

The first and last sentences of this quotation have already been widely quoted from tobacco industry sources. The part in italics (italics added) are likely to be quoted by anti-smoking groups. To say that the influence of advertising and promotion is unknown and possibly unknowable, may be conceded for the United States, given its size, the advertising saturation of the media, the degree of brand-share competition, and the difficulty of monitoring expenditures by a number of firms promoting tobacco in various media. The effect of promotion on consumption may be more amenable to research in smaller countries where tobacco advertising is already restricted to two or three media..

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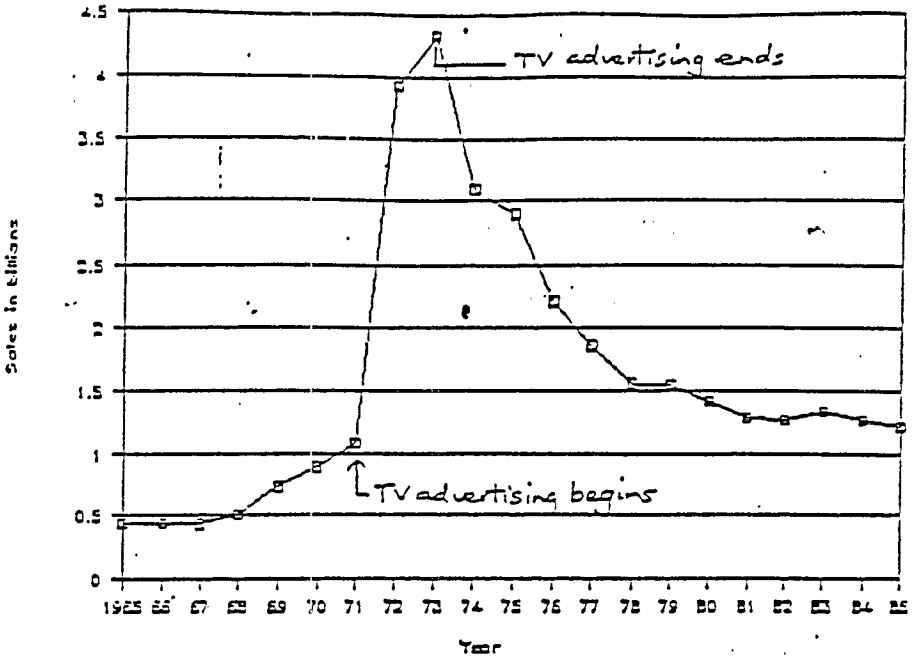
Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

1965-85



Source: Lee P N, Tobacco Consumption in Various Countries. Tobacco Quarterly 1979-88.
Tobacco Research Council, London 1975.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

From the United Kingdom and Europe

Despite widespread print, shop and commuter-targeted tobacco advertising, and many advertisements carrying warnings that smoking causes 30,000 lung cancer deaths a year, only a few published studies could be found on the tobacco advertising-tobacco consumption relationship in the United Kingdom.

A 1975 analysis of the link between advertising and demand for cigarettes in Britain in the 1950s and 1960s found that a 10 percent increase in advertising increased sales by 2 percent,[50] which in 1965 was equal to an extra 54 cigarettes sold per adult, about 5 packets *per smoker*, or, for the industry, an extra 2,240 million cigarettes sold per year.[51] In the light of comments received this figure was subsequently revised downwards.[52] A more recent investigation (1985) confirmed the 1975 findings, reporting a positive, small but significant effect on cigarette consumption.[53]

'Small' the effects may have been, but as noted elsewhere in this report and in various parts of this literature review, even small rises in consumption can translate into considerable increases in numbers of cigarettes actually smoked.

In the 1970s, the British tobacco industry commissioned the French consulting group Metra to explore the relationship between total cigarette advertising and total cigarette consumption in the United Kingdom.[54] Poster, press, magazine and coupon advertising were taken into account; sponsorship was not. Metra used tobacco industry data almost exclusively, data which has never been made public (their document includes a graph for industry advertising, but the pounds sterling expenditure figures are omitted), and avoided the opportunity to use the same data as the 1975 study. Using quarterly data only, Metra showed no relationship between tobacco advertising and sales in the United Kingdom for the period 1957 to first quarter 1978. At this point, recognition should be given to the fact that advertising does not pay off in extra sales in all countries at all times. The British tobacco industry suffered disastrous market flops with tobacco substitute cigarettes launched at a cost of 70 million pounds in July 1977,[55] near the end of the period studied by Metra.

A West German study in the 1970s by Reuijl and others was unusual in that it was conducted independently of the tobacco industry but with full access to annual, bimonthly and monthly data.[56] The findings of this study contradicted those of Metra: 'advertising was found to have a statistically significant impact on industry sales, although the influence diminished over time.' The results contradicted the official (industry) view that advertising only affects brand-shares without affecting total consumption. Based on 120 monthly observations, a 10 percent lift in advertising expenditure was estimated to increase sales 1.4 percent. This, in 1970, would have meant an extra 35 cigarettes consumed per West German adult (4 packs *per smoker*), an extra 16,540 million cigarettes sold each year.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Reuijl's work has been reviewed as being 'totally flawed' because of its exclusion of key marketing factors - price and seasonality. This criticism,[57] quoted by the British Advertising Association, would appear to be unmerited, as Reuijl clearly states that he considered price but excluded it when he found that it had almost no effect; moreover Reujil analysed advertising effects on four price segments of cigarette brands from low to premium, and found positive effects in all segments.[58] As for seasonality, Reuijl found the same positive effects on yearly data as with more frequent data where seasonality might be a factor.

From Australia

In both Australia and New Zealand, British American Tobacco (Wills or Amatil) dominated the market till displaced by Rothmans. Phillip Morris manufactures in Australia and exports to New Zealand. From 1954 to 1967, advertising expenditures by the tobacco industry in Australia rose 2,248 percent and sales by 87 percent.[59]

An investigation of advertising expenditure and aggregate demand for cigarettes in Australia published in a 1986 issue of the *International Journal of Advertising* found no relation between total expenditure on press, radio, television advertising and total cigarette sales. No measure, however, of outdoor, cinema or sponsorship advertising was provided.[60] Sponsorship advertising expenditure was $8 million out of a total of $36 million in the 1979-80 year.[61] About 100 new brands were introduced between 1960 and 1967,[62], and thereafter costly new brand launches were more likely to fail. No effect on sales was found in 1976-7 from the ban of cigarette advertising on television, but some of the ban's intended effect had probably been achieved before this by the warnings that were required on television from 1972.[63]

From New Zealand

Although the tobacco industry has never published its advertising expenditures, one market survey firm monitored advertising by all tobacco manufacturers in the press and magazines from 1973. For the years 1973 to 1986, press and magazine cigarette advertising expenditures were purchased by the Department of Health and made available, along with data on price, income and cigarette releases for sale, to two separate groups of researchers at the University of Canterbury and Victoria University of Wellington.

The two papers documenting the results of the groups' studies of the data show that while each took a different approach, each found that, other factors being equal, advertising increases total industry sales beyond what they otherwise would have been and tends to increase sales for some months following placement of the advertising.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

The abstract of the Canterbury study, published in 1988, is quoted here:

> The relationship between cigarette consumption and cigarette advertising was studied over the period 1973 to 1985. The data on cigarette consumption were drawn from government statistics. Expenditure on cigarette advertising included only that on print media advertising. Both quarterly and annual time series were examined and two different models were estimated. Results from the quarterly analysis suggested that advertising did affect overall consumption, with an elasticity of +.07. The carry-over effect of advertising lasted for approximately 4 quarters. Analysis of the annual series produced few meaningful results, suggesting that use of the longer time period may mask significant relationships

The Canterbury paper was quickly challenged on a number of technical grounds.[64] After further analysis along the lines suggested, the Canterbury group recently reported that

> ... the original model and conclusions appear to be very robust, and the additional long run analyses indicate that the impact of cigarette advertising on consumption may, in fact, be larger than was indicated in the original work.[65]

To many, an elasticity (the percentage increase in sales from a 1 percent increase in advertising) of +.07 would appear negligible. As a tobacco industry's consultant commented, 'Who would find such an (advertising spend) increase justified by such a miniscule and doubtful return?'[66] However, a positive elasticity of +0.07 implies substantial profits. Using the Meads results (and assuming that tobacco prices and personal incomes remain constant) we apply the ex-factory selling price of 66.7 cents per packet of 20 cigarettes to the 1988 sales in New Zealand of over 5,300 million cigarettes. A 10 percent increase in print media advertising expenditures, which would have cost the industry $470,000 in 1988 dollars, should have generated a 0.7 percent increase above the level of sales without any such advertising, an increase in terms of factory sales of $1.17 million.

While not all of this would have been profit, these sales can be regarded as additional (after most overheads are paid for): the machines would have to run only a few minutes longer each day. Some profit should therefore have accrued, the more so when it is realised that advertising is a tax-deductible operating expense.

The abstract of the study undertaken at Victoria University of Wellington stated that:

> Real price, cigarette advertising, and an income measure, were studied in relation to total advertising sales, using monthly data from 1973 to 1986. A real price rise has a larger effect on sales than a real price fall. Smokers appear to respond to nominal price increases rather than to falls in real price.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

> Cigarette price and advertising has significant short run and cumulative effects on cigarette consumption. An increase in the real price has approximately the same effect in reducing consumption, as the same percentage reduction in advertising expenditure. The effect of taxation in reducing consumption can be neutralised by increased cigarette print advertising.[67]

Both the Canterbury and Victoria studies show that with a 10 percent rise in advertising expenditure consumption would rise at least 0.7 percent (Table 6.2.2). On 1988 sales, this equals 37 million cigarettes per annum for a total population of 3.3 million and 2.5 million adults.

Meads' study and the latest revision of Chetwynd's study show a net effect of advertising on consumption, over and above any reverse effect of sales on advertising budgets. What would be the effect of a total ban on tobacco advertising in New Zealand on tobacco consumption per adult? Meads met the Subcommittee and explained that with an elasticity (the effect of a 1 percent change in advertising) of +.07, a total ban, equal to a 100 percent reduction in tobacco advertising, would have the effect of lowering tobacco consumption per adult by 7 percent. Most of this effect would occur as a once-only drift downwards in the first five months after a total ban, but remain thereafter as a permanent background effect. Meads noted that any effect on young people not taking up smoking in future years was beyond the range of his study to detect, and would therefore be additional to the 7 percent. The advertising ban may indeed through its effect on young people, Meads said, have a very gradual cumulative background long-term effect on the national total tobacco consumption per adult, over and above the once-only effect noted above.

Tobacco manufacturers later pointed out to the Subcommittee that falls of this magnitude have not occurred in any country after any advertising ban. This may be so, but as Meads points out that

(1) The decrease should be measured not against the pre-ban year's consumption, but against what the tobacco consumption would have been if the ban had not occurred. (We plot time in years on the horizontal, and consumption on the vertical axis, and visually project the direction of consumption forwards in time.) Whatever the projected consumption, after a ban, other factors being equal, consumption should fall below forecast. If consumption is projected to fall, it should fall an additional 7 percent after a ban.

(2) The 7 percent decrease assumes that other factors such as real tobacco prices and per capita incomes remain the same as in the year before the ban. (If this does not hold and government relies on the ban alone and does not for example, raise tobacco taxes for several years after the ban, a nil net effect is not only possible, it is almost certain.)

Further, econometric studies of advertising have been criticised as being unreliable for predicting the effects of a total ban. However:

(1) While the elasticity results of econometric studies cannot be confidently extrapolated beyond their range, advertising in New Zealand varies within wide limits - during the period 1973 to 1986 annual print advertising

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

varied by 252 percent. The elasticity for a 100 percent fall can thus be calculated without extrapolation.

(2) The estimated decrease in consumption from a total advertising ban is *conservatively* estimated at 7 percent. Although elasticities calculated from econometric studies only hold true at the mean for the dependent variable (in this case consumption), the effect of a total ban will lower consumption and increase the effect so that the increase will, if anything, be slightly higher than simply 100 times the elasticity. After this correction, it is calculated that consumption will tend to fall by 7.5 percent.

take in Table 6.2.2 about here.

Table 6.2.2 Long run effects (elasticities) of advertising on cigarette consumption per adult in New Zealand, 1973-86

A 10 percent change occurs	Observed change as a percentage of total sales
In price	-1.4
In cigarette print advertising $	+0.7

Source Chetwynd et al. *Brit. J. Addiction*, (1988) 83,p.409-414
Meads C. and Evans L. (1988) in press.

6.3 The relationship between advertising, smoking and ill-health

Conclusion 1

Advertising is directly related to the number of cigarettes smoked; increased advertising means more cigarettes smoked, and less advertising means fewer smoked. (For the evidence, see 6.2 above and chapter 7.)

Conclusion 2

Lung cancer and heart disease rates are directly related to the number of cigarettes smoked. (For the evidence, see chapter 2, and Appendix 1 under lung cancer and cancer disease.)

Of particular importance in relation to the early adoption of daily smoking in New Zealand (see 4.1) and in other countries, a younger age of commencement of smoking increases the risk of lung cancer (Figure 6.3).

Figure 6.3 The risk for males of dying from lung cancer according to the age at which smoking commenced, relative to the nonsmoker's risk taken as equal to 1.0)

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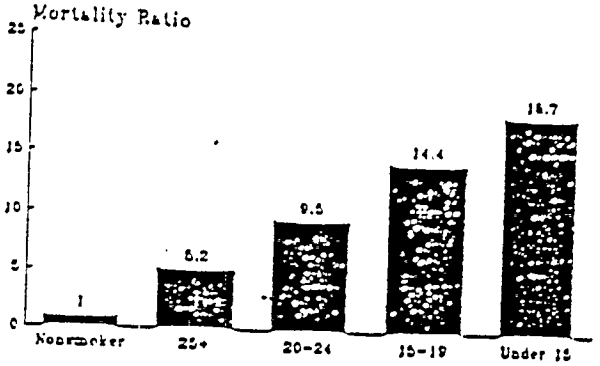
Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000



SOURCE: U.S. Veterans (Kahn 1966).

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Conclusion 3

The effect of advertising on cigarette consumption can be substantial. As noted in 6.2 above, even a 10 percent rise in advertising will tend to increase consumption by 0.7 percent, that is by 37 million cigarettes in a year.

Conclusion 4

Changes in cigarette consumption of this magnitude will produce significant changes in death rates. This can be deduced from the high numbers exposed to the risk, the intensity and duration of that exposure, and the high relative risks of smokers for a number of common serious diseases.

Numbers exposed to risk

The 28.7 percent of adults smoking cigarettes (including hand rolled cigarettes) in 1988 meant 730,000 New Zealand adults were at serious present and future health risk in the long or short term from smoking.[68]

Intensity of exposure to the risk

In New Zealand in 1988 the average smoker smoked 8,095 cigarettes, or 22.2 cigarettes per day.[69] Assuming an average yield of 15mg of tar per cigarette (the yield is indicated on the packet) then 22.2 cigarettes per day adds up to 121 grams of tar (carcinogenic solids) inhaled by the average smoker per year, a dose over the last twenty-five years for most smokers of over 3 kilograms. Much of this tar is absorbed, and at any one time some of it lies in direct contact with the surface cells lining the main air passages. This is where lung cancer begins.

Deaths attributable to smoking

The number of deaths from smoking (estimated in 1988 to be 15 percent of all deaths[70]) is directly related to the total number of cigarettes smoked. Formulae are available relating cigarette consumption to both lung cancer and coronary heart disease death rates.[71,72,73]

Relation of smoking to disease

Reductions in tobacco consumption mean, in both the short and the long term, substantial reductions in premature coronary deaths (see 12.2).

It is the view of the Toxic Substances Board that the tobacco industry's total advertising expenditure can and has resulted in changes in national cigarette consumption of a sufficient magnitude to affect the health of thousands of smokers.

Between 1973 and 1986, advertising to the value of $60 million (in 1988 dollars) was placed by the tobacco manufacturers in New Zealand published newspapers and magazines. The total figure for all media was probably over $100 million in this period.[74] In the same period, over 15,500 persons died of lung cancer in New Zealand. Approximately 90 percent (or 14,000) of these were due to smoking cigarettes.[75]

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Cigarette smoke contains forty three carcinogens that are both cancer initiators and cancer promoters.[76] Once further exposure to these promoter carcinogens ceases, as when people stop smoking, the lung cancer risk begins to wane. An ex-smoker halves his or her lung cancer death risk in about five years.[77] Conversely, tobacco advertising, by influencing the number of cigarettes smoked as recently as 1984 will have affected the number of cancer deaths in 1989.

The risk of coronary artery disease is directly related to the number of cigarettes smoked.[78] The excess risks of heart attacks (coronary heart disease) in ex-smokers halves within two years. Conversely, by influencing more smokers to keep on smoking, advertising and advertising expenditures which occurred as recently as 1987 will have had an adverse influence in precipitating some of the 1,100 smoking-caused premature coronary heart disease deaths in 1989.

From the evidence presented here, tobacco promotion can be seen to act as a population-wide background risk factor for diseases for which smoking is the major or a major cause, such as lung cancer and coronary heart disease

6.4 The effects of tobacco advertising on young people

Summary

Smoking is rare among children at age 10 or 11 in most countries[79] but by age 15 one in four have become smokers (Table 4.1.1). New Zealand children are repeatedly exposed to cigarette advertising. Moreover, their knowledge of brands and slogans indicates that they not only read but remember the advertisements. At ages 10 to 12, as a University of Newcastle New South Wales study has shown, a child's attitude of approval to tobacco advertisements is a predictor of substantially increased risk of uptake of tobacco smoking, and for smokers at that age, predicts a substantially lower chance of quitting.

Advertising influences adults' smoking (6.2) and adults influence children's uptake of smoking. Thus apart from any direct effects, advertising has undoubted indirect influences on children. The main issue for discussion here, however, is what factor or factors are operating between ages 10 and 15 that lead to 15-year-olds becoming daily smokers?

6.4.1 Exposure of children to tobacco advertising

In the years before taking up smoking, children are exposed to many cigarette advertisements in newspapers. On any given night Monday to Saturday, 43 percent of teenagers aged 10 to 14 in the five main centres, in 1986, read newspapers.[80] In magazines, cigarette advertisements are often prominently placed, and so undoubtedly some children will see some of them.

The average New Zealand household buys publications containing hundreds of cigarette advertisements each year. A home receiving *The Evening Post*, *The New Zealand Listener*, each week, and the *Dominion Sunday Times* each weekend, was exposed in 1985 to a total of over 200 cigarette advertisements, one per 48 hours.[81] (Newspaper advertising expenditure by the tobacco industry then increased 58 percent between 1985 and 1988.[82]).

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Seventy-eight percent of New Zealand children in the age group 7 to 15 years reported having seen cigarette advertising.[83]

The tobacco manufacturers' position is that tobacco advertising is not directed at children. What is at issue here, however, is not intentions, but actions and effects.

In 1987 the manufacturers agreed not to advertise in certain low circulation magazines (*Dollie*, *Charlie*) with a high *percentage* of their readership among adolescents. Tobacco manufacturers were, however, unwilling to stop advertising of tobacco in family magazines such as the *The New Zealand L Listener*, which has one of the highest teenage readerships of any New Zealand periodical.[84] Any restriction on advertising in this magazine to protect children would interfere with the manufacturer's freedom to advertise his products in a magazine which also has a high circulation to adults.

As long as the right of manufacturers to advertise tobacco to adults is upheld, children will inevitably be exposed to tobacco advertising. The question then becomes one of which right takes precedence - that of the tobacco manufacturers to advertise products which have been established as a grave health hazard, or that of young people and ultimately society as a whole, to be free of the social and economic costs of this hazard?

6.4.2 Advertising's effects on children's knowledge and attitudes

Children are more aware of cigarette advertising and brand imagery than adults realise. Form one smokers in New Zealand (age 11) know four brands on average (range 0 - 20 brands), and never-smokers know two brands on average (range 0-14 brands). Four-fifths of Form 1 smokers could name a preferred brand,[85] and underage smokers were found to be more aware of these matters than the other children.[86] Other studies have found that children recognise cigarette advertisements and can complete the advertising slogans.[87] Children's contact with advertisements goes beyond simple exposure, for they see and remember them.

Children's perceptions and viewpoints on tobacco advertising

What do children see in advertisements? University marketing department staff in Scotland interviewed twenty-four groups of students between six and sixteen years of age and asked them to comment on the what they saw in fifteen current advertisements, amongst which were six advertisements of common cigarette brands. Most 14- and 16-year-olds and some 12-year-olds also, perceived cigarette advertisements in much the same way that young adults do.[88]

For example, an advertisement containing John Player imagery promoting holidays was thought to be advertising cigarettes by 22 percent of the primary school children and 91 percent of the secondary school children. The researchers found that an advertisement for Kim cigarettes, designed to appeal to working women in their 20s and 30s, appealed also to most 14- and 16-year-olds, and some 12-year-olds, and they concluded that any advertising campaigns targeted at young adults would therefore be likely to present qualities which young teenagers would find attractive.[89] If advertising is 'getting through' to adults, it is probably 'getting through' to children also.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Over 90 percent of 1,254 Hamilton, New Zealand, 10- to 16-year-olds felt tobacco companies advertise to get them to buy their brands. Over 70 percent of the non-smokers and about 40 percent of the smokers in this sample disapproved of cigarette advertising.[90]

6.4.3 Children's report of factors influencing their first cigarette

In Dunedin in 1988, 80 percent of 15 year olds had at least taken a puff of a cigarette, but only 15 percent were daily smokers.[91] In this section the factors influencing experimentation with the first cigarette are examined.

The Children's Research Unit multi-national surveys

At its meeting on 3 March 1989, the Board's Tobacco Subcommittee met with Mr Glenn Smith, Director of the Children's Research Unit (CRU), London, a market research group. Smith explained at some length the multinational study carried out by his Unit on the factors which influence children to take their first cigarette. New Zealand was included in the study. He stated that the study observed that advertising was not a significant reason influencing children to try their first cigarette.

As was pointed out, however, by Dr Phillip Silva of the University of Otago, the Board's consultant on children and smoking, cross-sectional studies like those of the Children's Research Unit are inherently incapable of answering the question of interest:- Does advertising influence a proportion of children who try their first cigarette at say, age 9, to become daily smokers or addicts some years later? Furthermore, Dr Silva's study of Dunedin children up to age 15 years has shown that smoking a first cigarette at age 9 bears no relation to daily smoking at age 15.

Dr Silva's study was not oriented towards the question of advertising and smoking uptake by children and, therefore, like the Children's Research Unit study, cannot give a definite answer on the role of advertising during the critical years 12 to 15.

CRU have done work for the international tobacco industry's information group, INFOTAB in Brussels, for some years. Surveys of children in ten other countries had already been carried out on children interviewed at home on their smoking habits, and published as a brochure of the International Advertising Association Inc. of New York, edited by JJ Boddewyn.[92] The World Health Organisation has criticised the IAA report for its dubious inter-country comparisons, its assumptions and for the deficiencies of its literature review.[93] Mr Smith informed the Subcommittee that the number of countries surveyed would soon total sixteen, and repeat surveys were planned for some countries.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Using an almost identical method to that of its multinational investigations, in 1988 CRU arranged through a local survey firm for the interview in their homes, about their smoking habits, of one thousand New Zealand children aged 7 to 15 years of age. New Zealand children were also asked to think of the reasons for taking their first cigarette, at first unprompted, then prompted, by being shown a list of thirteen possible reasons. In other countries very small percentages selected 'I saw an advertisement' as a first choice out of 13 offered, as a reason for taking the first cigarette. In New Zealand none selected this, either unprompted or prompted. Second and third choice selections from the 13 possible reasons for smoking were asked, but were not reported. The survey report summarises the advertising effect as 'insignificant' with regard to smoking initiation (based on the answer to this question).[94] The report has been released to the media but has not been published in any scientific journal.

The CRU survey by focussing on the *first* cigarette distracts attention from the more important period, from first cigarette to daily smoker. For the important question is this: 'Of all the one-cigarette puffers, what persuades some, and only some, to become occasional smokers, and some occasional smokers to become regular smokers, and what is the role of advertising in this regard?' As Smith pointed out, that would require a different study.

The small numbers interviewed at any given age implied considerable sample errors. The age group 7 to 15 years is an unusual one, making comparison with other surveys almost impossible. Since smoking prevalence rises steeply before age 15, ages of greatly varying smoking prevalence have been lumped together in the tables of results.

The CRU survey assumes children can assess subtle forces such as advertising and parental influence. Using the same type of reasoning, one can argue that since only 3 percent pointed to 'my parents smoked' as their reason for trying their first cigarette, parents' smoking influences only 3 percent of children to smoke or not. Most studies would assign greater importance to parental influence than this. No evidence was provided that children are in fact capable of assessing correctly the effect of tobacco advertising on their present or future smoking habits.

The Board agrees that curiosity is an important factor in young children trying their first cigarette, but as most children try one cigarette, the Board felt that this survey was not relevant to the Board's concerns, which are (1) how to lower the percentage of children becoming daily smokers, and (2) the role of policy-amenable factors such as tobacco advertising in influencing the uptake of daily smoking.

6.4.4 Influences affecting daily smoking

There is a lag of 2.4 years on average between first cigarette and daily smoking.[95] During this time, children oscillate in how they describe their smoking status[96] and policy-amenable factors such as tobacco advertising and advertising controls have ample time to exert any effect they may have.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Combined cross-sectional and longitudinal studies

In studying the effect of government policies, only a combined inter-country and longitudinal approach will answer the question 'What mixes of government policies will most effectively reduce uptake of smoking by young people?' In the long run specially designed studies are needed. The international tobacco industry has already through CRU begun to convert their cross-sectional survey into a longitudinal one.

Using available survey results from nineteen countries, a combined longitudinal and cross-sectional study is reported in Chapter 7. The countries were grouped grouped according to their extant tobacco advertising restrictions. Annual rates of decrease in smoking among young people have been used to allow inter-country group comparisons. Results are shown inTable 7.5.1b and Fig.7.5.1b. Increased advertising controls are accompanied by reductions in smoking in young people.

Cross-sectional or inter-country comparisons in the same year.

Once-only *cross-sectional* or *inter-country* comparisons of countries with different tobacco advertising or other tobacco control policies, fail to answer the basic concern of the extent to which these policies affect the *rate* at which smoking is declining. To measure rate of change, several observations in time are needed. (See 8.2.4 for CRU comparisons between New Zealand and Norwegian young people.)

A six-year longitudinal cohort study

To elucidate cause and effect, to prove that certain influences reduce smoking at age 15, studies tracking the same young people through time, or *longitudinal cohort* studies, are needed.

If the same group of children can be followed then deductions can be made about the effect of influences on them. In the Dunedin multi-disciplinary study at the University of Otago, as Dr Silva, the study's director, explained to the Subcommittee, nearly 1000 Dunedin-born children have been followed from birth to age 15 years, with 95 percent interviewed at age 15. Questions on smoking were asked at ages 9, 11, 13, and 15 years.

A one-year longitudinal cohort survey

At ages 10 to 12, attitudes to advertising have been studied in relation to smoking behaviour the following year, at the University of Newcastle, New South Wales.[97] In this randomised controlled trial, 5,686 10- to 12-year-olds completed an anonymous self report questionnaire, with the researcher present and teacher absent, in 1979, and again a year later.

On the 1980 self-report questionnaires, there was a difference of 15 percentage points in adoption of smoking between children who had approved of advertising in 1979 and those who did not (Table 6.4.4a). Children who approved of cigarette advertising (in 1979) were twice as likely to be smokers (in 1980) as children who disapproved. Those who were smokers and who disapproved of cigarette advertising in 1979 were more likely to have quit by 1980 than smokers who approved of it (Table 6.4.4a).

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Table 6.4.4a Percentage of 10 to 12 year olds taking up smoking, and percentage of the smokers quitting in 1980, by attitude to cigarette advertising in 1979

	% nonsmokers taking it up	% of smokers quitting
Approve cigarette advertising	27	34
Disapprove cigarette advertising	12	46
% difference linked with advertising	+15	-12

Note n = 5686
Source Alexander HM et al. *International. Journal of Epidemiology* 12,(1), 1983, p.59-66.

The Newcastle researchers concluded that 'approval of (cigarette) advertising, was 'an important predisposing factor.' (defined as a prior factor which provides the initial motivation for the smoking).

Child smokers who approved of cigarette advertising were one quarter less likely to quit. This finding suggested that their attitude (to advertising) is a reinforcing factor (defined as related to the maintenance of the smoking behaviour). The difference is marked (Table 6.4.4a).

Besides these predisposing and reinforcing effects of cigarette advertising, the enabling factors are access to cigarettes and pocket money (Table 6.4.4b). Obtaining cigarettes is not a problem for the half of all New Zealand children who live with an adult smoker in the house.[98] Approximately one third of young mothers now smoke and have cigarettes in the house.

Table 6.4.4b Rank order of importance of attitude to cigarette advertising and other factors as predictors of 10- to 12-year-old children taking up smoking or, if smokers already, of giving it up

Rank	For taking up smoking	For quitting
1	age : one year older	siblings don't smoke
2	friends who smoke	age: one year younger
3	siblings smoke	disapproves of advertising
4	approval of advertising	less money to spend weekly
5	have more pocket money	

Source Alexander H.M. et al. *International. Journal of Epidemiology* 12,(1), 1983, p.59-66.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

6.4.5 Indirect effects of tobacco advertising

Indirect effects, that is, the effects of advertising on the child through parents and peers, are of undoubted importance:

- o Advertising influences adults to smoke more, or more adults to become or stay smokers, as shown in 6.2 above.
- o Children's smoking is influenced by their exposure to smokers among their parents and family members [99]
- o Advertising through parents therefore indirectly influences the smoking habits of the children, aside from any direct effect.

6.5 The effect of sponsorship advertising

6.5.1 Exposure to tobacco advertising through televised cricket

A televised cricket test was monitored in 1987.[100] Counting only the times when the tobacco brandname (Rothmans in this instance) on perimeter ground signs were clearly readable, the brandname could be read for a total of 18 minutes per playing day. This was equivalent to 38 percent of the time given to commercial advertising breaks during the televised cricket. Allowing for the fact that the advertiser can communicate only the brandname, by using the usual dilution factor of 0.3, the signage shown during one test was the equivalent of eleven 30-second commercials, or 55 in a season. The real value of such advertising may, however, lie elsewhere.

- o Televised tobacco brandname exposure can be obtained in no other way - television advertising of tobacco products was banned in New Zealand in 1963.
- o Sponsorship advertising of sport permits, but tobacco product advertising rules forbid, the association of sport and glamour with tobacco brandname.
- o Cricket is a much loved game, with a clean and healthy image, and through sponsorship a tobacco brandname is associated with prestigious international contests.
- o The sponsored sport helps polish the tobacco corporate image, and a healthy sport such as cricket gives the tobacco corporate image a healthy shine.

The audience watching this test comprised around 10 percent of the 1.5 million potential male viewers. The average number of young males aged 5 to 19 who were watching the test at any one time was of the order of 20,000. Many young women and girls also watched the tests, but in fewer numbers than this.

6.5.2 Sponsorship advertising acts as advertising to young people

To demonstrate that tobacco sponsored sport acts as advertising to children for tobacco products, it is not necessary to prove that it increases tobacco use by

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

children (many children may have formed an intention to smoke but lack the opportunity). All that is required is to show that:

- o the sponsored activity increases the level of awareness of certain brands
- o these brands are linked in the young peoples' minds with an attractive activity, in this case sport.

In 1984, snooker featuring the Embassy brand, was broadcast for 100 hours on BBC television. Samples of approximately 300 students, in their first, third and fifth years at secondary school, were surveyed before and after each Embassy snooker game on television. Sixty-nine percent watched the snooker and 44 percent remembered Embassy as the snooker-sponsoring brand. Awareness of the Embassy brand increased by 12.5 percentage points; its linkage with sport doubled, lifting by 25 percentage points.[101] To increase to this extent the awareness for the brand advertised in a known growth segment of the market is surely an adverriser's dream.

In the course of a national survey, less structured interviews with groups of New Zealand Form I students (age 11 years) showed that sponsorship advertising has successfully linked healthy sport with tobacco brand-names on the television screen and, it appears, in children's minds.[102] It appears that tobacco sponsorship acts as advertising to children in New Zealand also.

It is not necessary to imply that tobacco manufacturers in the United Kingdom or New Zealand intend to influence young people by their sponsorship. It is sufficient to point out that, intended or not, sponsorship acts as tobacco advertising to children.

6.5.3 Effect of sponsorship on adult tobacco use

Although no published econometric studies on this point could be found, the tobacco industry worldwide and in New Zealand regularly monitors its sponsored activities, and annually commissions extensive polls on smoking habits.

These polls asked heads of households whether their own consumption of motor oil, tobacco or liquor had been influenced by the sponsorship activities of companies in these fields. Four percent in 1978, 4 percent in 1982, and 3 percent in 1988 said yes.[103] Unfortunately, a specific answer on tobacco sponsorship was not supplied.. Assuming that for tobacco sponsorship 3 percent of all (smoking) adults were influenced in 1988, this is a satisfactory marketing result from the industry's point of view.

Three percent of smokers influenced is also important from a public health point of view in New Zealand; if one third of the 3 percent influenced were influenced sufficiently to keep on smoking for another year, that represents 7,300 smokers who missed the chance to lower their risk of premature death from smoking-induced disease.

In September 1988, to the question 'Sponsorship of sport by cigarette companies will not encourage me to take up smoking', 93 percent said yes, 1 percent did not know, and 6 percent disagreed.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

To the question 'Sponsorship of sport by cigarette companies does not increase the number of cigarettes I smoke, only 82 percent agreed, 1 percent did not know, and 17 percent agreed.104

For their parent companies, British American Tobacco and Rothmans, the New Zealand manufacturers, through events televised in New Zealand but broadcast overseas, help raise awareness for their leading brands (*Rothmans* and *Benson and Hedges*) among larger television audiences than New Zealand can provide. Similarly, television of sport overseas helps raise cigarette brand awareness for some of the brands on sale in New Zealand.

While in a recent study, no relation was found between the number of hours of tobacco sponsored events on television and monthly cigarette sales per adult up to 12 months later[105] tobacco sponsorship effects on consumption may, actually, be present, but just difficult to demonstrate statistically. Also this study[106] had technical problems in detecting any effect in New Zealand because sponsorship was concentrated in the first quarter of the year. The following should also be realised:

- If children's intentions are influenced towards smoking by tobacco sponsorship towards smoking, this influence may not show up in sales figures for some years till the children are of sufficient age - the *sleeper effect* of advertising.

- Hours of viewing do not necessarily measure how much tobacco advertising is seen. Frequency and duration of the appearance of tobacco advertising signs per hour of televised sport has been found in the United Kingdom to vary greatly from year to year for the same event.107

Finally, sponsorship is not charity, and if the pay-off was not there in the long or short term, it would not be undertaken.

6.5.4 Conclusion

The necessary data to prove or disprove any effect of televised tobacco sponsorship on consumption are costly to obtain, and are held by the industry. Such studies, however, of direct consumption effects may miss the main point of tobacco sponsorship advertising. Tobacco sponsorship, besides creating future demand for the advertised brandname, helps defend a climate of social acceptability for continued promotion of tobacco products, against a continual barrage of adverse health reports on the consequences of tobacco use.

6.6 The economics of tobacco advertising, brand-switching and the teenage tobacco market

Summary

Advertising is said to promote brand-switching, instead of increasing market size, but analysis of this argument lead to the conclusion that brand-switching only justifies economically 7 percent of advertising expenditures.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Tobacco manufacturers spent an estimated $11.4 million in New Zealand in 1988 in promoting tobacco (see 5.1). Cigarette advertising in the print media increased greatly from 1987 to 1988,[108] in association with many new brands released and a marked reduction in company taxation rate.

Tobacco advertising expenditure can be economically justified by generating extra sales either from -

(1) current smokers switching to the advertised brand
(2) ex-smokers taking up smoking again or, current smokers persuaded to smoke more cigarettes, or
(3) more new young smokers being persuaded to start than would have otherwise.

Detailed calculations show that tobacco manufacturers are now probably spending in excess of ten times more per year on advertising than they are likely to gain in the same time by brand-switching. Brand-switching, the industry's justification for advertising, accounts for only 7 percent of the economic return from maintaining tobacco advertising and sponsorship. This is the best estimate of the situation in the light of information that is currently available in the public domain. The conclusion is that over 90 percent of the tobacco advertising expenditure can only be recouped if tobacco advertising increases the number who smoke, particularly by attracting new smokers to smoking.

Where, as in New Zealand, there are only two main manufacturers (an oligopolistic market in economic terms), and advertising is permitted, then advertising, much of it in support of new brand launches, and backed up by sponsorship to raise brand awareness, becomes the main method of competition, rather than price. When two firms compete, whether in the media, or through 'below the line' advertising via other promotions, to the tune of approximately $11 million dollars expenditure per year, tobacco consumption is affected, as shown in 6.2 above. Increased tobacco consumption per adult may not be the intended effect of individual company activity, and there is no need to assume otherwise, but nonetheless tobacco promotion, other factors being equal, raises consumption per adult in relation to what it would have been otherwise. Even for the industry as a whole, there is no need to postulate that the industry plans its advertising to raise consumption, but only to note that tobacco promotion by the industry as a whole raises consumption per adult.

6.7 Indirect effects of cigarette advertising on coverage of smoking issues

In the United States, the coverage of smoking and health in the media, particularly magazines, has been found to correlate with the percentage of advertising revenue from tobacco of those publications. This is an issue of public health importance, because the printed word is assumed to be influential in enlarging public understanding of health issues and risks, including knowledge of smoking and its risks, which in turn affects smoking behaviour. Therefore, if for fear of losing advertising revenue, coverage of smoking issues is reduced, the public is deprived of information that might otherwise have lead to reductions in smoking and improvements in health.[109]

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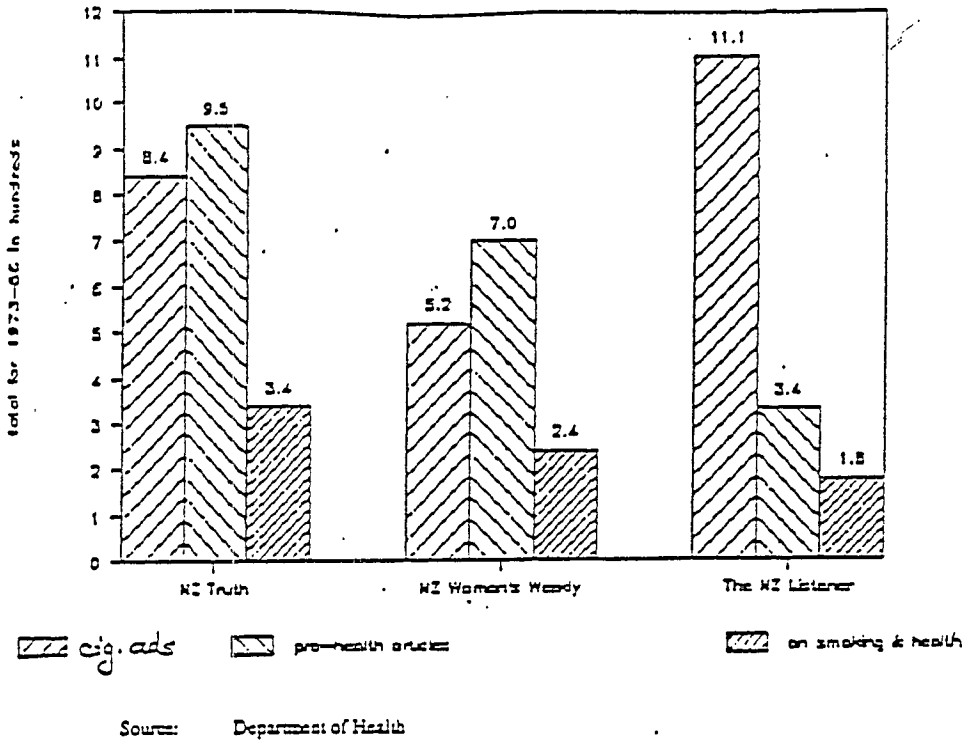
Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

& health articles, 1973-86 in leading New Zealand periodicals



Source: Department of Health

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

A count of leading New Zealand publications shows that *the number of pro-nonsmoking articles is abnormally low, a mere 4 percent of all health articles* (Table 6.7a). When it is remembered that smoking causes 15 percent of *all* deaths (Table 1.3), and an even greater percentage of clearly preventable deaths, smoking as a health issue has clearly been down-played in these publications. There is no evidence that the health consequences of smoking are *deliberately* muffled; if they were, it could be as much due to editorial decisions to not offend smoker-readers, as to management decisions not to offend advertisers.

Whatever the reason, the effect is clear: the number of cigarette advertisements in leading New Zealand magazines since 1973 has outweighed any major message to the contrary by a ratio of 32 to 1, a most unfortunate, misleading and unhealthy imbalance (Table 6.7a).

Table 6.7a Total number of cigarette advertisements, pro-health articles and pro-nonsmoking articles in three leading periodicals, 1973-86.

Periodical	Cigarette advertisements	Pro-health articles	Pro-nonsmoking articles
NZ Truth	843	948	34
NZ Woman's Weekly	521	700	24
The NZ Listener	1105	335	18

Source: Department of Health count of back issues

Publications vary in the percentage of their advertising revenue from tobacco (Table 6.7b), as does the editorial and reporters' treatment of smoking issues. News columns in many newspapers in recent years have given excellent coverage to smoking-health issues; others, much less. If the news or feature space given to smoking in one newspaper or magazine over several months is triple that of another larger newspaper or magazine, is it correlated with the percentage or amount of tobacco advertising revenue of the publications concerned (Table 6.7b)? There is no evidence to date for New Zealand publications that these variations in news column treatment and tobacco advertising revenue are correlated for individual publications.

Tobacco advertising, expressed as a percentage of *all* advertising (display plus classified), will be smaller than shown in Table 6.7b. After allowing for daily newspaper sales, tobacco advertising as a percentage of total revenue will be less still. The continuation of alcohol advertising revenue-wise is probably a matter of greater concern to most publications than the continuation of tobacco advertising. Only where a publication is struggling for other reasons might the presence or absence of tobacco advertising be critical to viability. Certain leading publications take no tobacco advertising on principle, notably *Grapevine*, and *Reader's Digest*.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Table 6.7b Tobacco advertising revenue of selected major publications, 1988

Publication	Tobacco advertising $'000 a	Total Display advertising $'000 b	Tobacco advertising as a % a*100/b
Dailies			
NZ Herald	899	42,327	2.1
Evening Post	219	19,757	1.1
The Press	219	14,120	1.5
The Dominion	190	9,573	2.0
Auckland Star	188	12,171	1.5
Christchurch Star	101	7,460	1.3
Weekly Newspapers			
Sunday Star	164	7,218	2.3
NZ Truth	122	745	16.4
Magazines			
The NZ Listener	289	18,550	1.6
NZ Woman's Weekly	125	11,293	1.1
More	28	5,020	0.6

Note: Tobacco advertising here includes a very small amount of advertising for smoking accessories.

Source: Hunter AGB, 1989.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

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7 REPORT OF A STUDY ON THE RELATIONSHIP BETWEEN GOVERNMENT TOBACCO PROMOTION POLICIES AND TOBACCO CONSUMPTION TRENDS IN 33 COUNTRIES 1970-86

7.1 Scope of the study and Summary

The Tobacco Subcommittee of the Toxic Substances Board commissioned the study presented in this section of the report and carried out by Department of Health staff as background information to address the question, 'Do advertising bans work?' To provide an adequate answer, the question has been broken down into three sub-questions:

1) Are advertising bans accompanied by falls in consumption?

2) Do advertising bans impede the free flow of information about less dangerous cigarettes?

3) Are tobacco advertising bans worthwhile?

Questions 1 and 2 are examined in this present chapter (7), and Question 3 is explored in Chapter 8. (Chapter 8 looks in detail at those countries which have had the most complete bans for the longest periods of time among the countries investigated in this Department of Health study.)

Whereas Chapter 6 gave the *predicted* effect of a 100 percent change in advertising expenditure on tobacco consumption based on observations in various individual countries, this study goes further and includes *observed effects* in groups of countries of the effect of a 100 percent fall in tobacco promotion expenditures, which is what a total ban on promotion implies.

The thirty three countries studied provide over 400 years of observations of differing levels of tobacco prices, personal incomes and advertising controls, including the effects of total tobacco advertising bans.

According to the data available, different groups of countries are reported on in relation to their prevailing tobacco promotion policy.

- For thirty three countries tobacco consumption per adult is reported in relation to the tobacco promotion policy in force.
- For nineteen countries the rate of change in the percentage of young people who smoke is reported.
- For twenty countries the rate of change in the percentage of adults who smoke is reported.
- For thirty countries the rate of increase in manufactured cigarette market share for filters as opposed to plain cigarettes is reported. This is to answer the industry viewpoint that advertising bans interfere with the free flow of information.
- Fifteen countries are studied individually in Chapter 8.

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Summary

To answer the question, 'Are tobacco advertising bans accompanied by falls in tobacco consumption', tobacco consumption per adult and advertising control levels were compared for the period 1970 to 1986 in thirty-three countries. Tobacco price data were obtained for thirty one countries and per capita income trend data for all.

The findings for thirty-three countries show that:

Government tobacco advertising bans and controls are accompanied by enhanced rates of fall in tobacco consumption; in the absence of any such control, consumption increases.

- Total tobacco promotion bans for health reasons are, on average, accompanied by falls in tobacco consumption which occur 4 times faster than in partial ban countries.
- The annual rate by which tobacco consumption, adult smoking rates and teenage smoking rates fall is graduated, with maximum effect in total ban countries.
- The next most rapid average declines in tobacco use are in countries where tobacco is promoted in only a few media.
- The decline in tobacco use is slower still where tobacco is promoted in most media but not on radio and television.
- In the few countries where tobacco is still promoted in all media (that is virtually unrestricted promotion), consumption increased (Table 7.5.1c, Figure 7.5.1c).

In short, the study found that the greater a government's degree of control over tobacco promotion, the greater the annual average fall in tobacco use in adults and young people (Figure 7.5.1a, Tables 7.5.1a,b,c).

7.2 Various types of advertising bans

Countries have eliminated tobacco advertising for varying reasons - for health, politico-ideological, trade, religious - and with differing effects on tobacco consumption.

Total tobacco advertising bans

The first total bans of tobacco advertising for health reasons took place in Scandinavia, in Iceland, Norway and Finland. In these countries the public is now well aware of smoking risks. Health education to children is mandated, and children receive a clear 'don't smoke' message from society. The children in these total-ban countries are growing up free of tobacco advertising pressures, and tobacco consumption per adult has fallen.

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Sweden legislated a sub-total ban in 1975 and, failing to reduce consumption rapidly, was in 1988 considering a total ban.[1]

For political reasons, centrally planned Eastern European economies do not permit advertising of consumables, including tobacco. In China, also, advertising has been non-existent, and only now is this beginning to change. Some countries have tried to protect state tobacco monopolies from imports by restricting advertising. Others have banned tobacco promotion in line with Islamic religion.

Whatever the reason for the ban, it seems that the public needs to receive a clear 'don't smoke' message from government through the combined methods of education, proper enforcement of the ban and price policy, to ensure a decrease in tobacco consumption.

Tobacco promotion permitted in few media

A few countries, such as Singapore, Sweden, Belgium and France, have legislated strong partial bans.[2] A few others, notably the United Kingdom and New Zealand, have 'strong' partial bans by government agreement with the tobacco industry: agreements restrict tobacco advertising to a few media, but manufacturers are unlikely to agree to curbs on advertising expenditure.

Permitted in most media

Most developed countries, for example, the United States, still permit outdoor advertising but disallow tobacco advertising on television and radio ('weak partial' bans).

Permitted in all media

Some countries, such as Japan, Greece and Spain, still allow tobacco advertising in all media without any effective controls.

For a listing of all countries known to have totally eliminated tobacco advertising, see Table 7.2.

Take in Table 7.2 about here

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Table 7.2 Eighteen countries which have banned tobacco advertising totally, and others which have legislated a strong ban, as of January 1989

Motivation	Country or state	Type of ban	Year begun
Health	Singapore	strong partial	1971
	Iceland*	total	1972
	Norway*	total	1975
	Sweden	sub-total	1975
	Finland*	total	1978
	Italy	partial enforced	1983
	Portugal	total	1983
	Victoria*	shops, sponsorship	1988
	S.Australia*	shops, sponsorship	1988
	Canada*	total	1989
Political	Albania*	total	pre-1982
	Bulgaria*	total	1980
	China	total	1949
	Czechoslovakia*	total	pre-1982
	Hungary*	total	pre-1982
	Poland*	total	1972
	Romania*	total	pre-1982
	USSR*	total	pre-1982
	Yugoslavia*	total	pre-1982
Trade	Italy	not enforced	1962
	Thailand	partial	1969
	Taiwan	partial	around 1970
Religious	Jordan	total	pre-1982
	Mozambique	total	pre-1982
	Sudan	total	1983
	Algeria	total	pre-1986

*Restricts tobacco sponsorship as well as advertising.

Source: *International Digest of Health Legislation*. World Health Organisation, 1982.
The left hand column is based on diverse sources (see Appendix 5).

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7.3 Previous studies of the impact of advertising bans

7.3.1 Hamilton's study of partial advertising bans

Statistician J.L. Hamilton presented his findings to the Third World Conference on Smoking and Health in New York in 1975,[3] analysing cigarette prices, incomes and cigarette consumption from 1948 to 1973, before and after the partial advertising bans (affecting television and radio) that had been introduced up to 1973 in seven Western countries.

Hamilton was unable to show any effect on consumption from the bans when the seven ban countries were compared with a group of four others where advertising was not banned before 1973. His econometric study included no measure of advertising apart from the date of the ban, and so he was unable to precisely formulate the problem mathematically; the equations were 'mis-specified' as Hamilton acknowledged. Finding that widespread publicity of the health hazards dampened growth in consumption, he advised anti-smoking groups to lobby instead for increased resources for education about smoking.

Hamilton mentioned that a major difficulty in his research was obtaining data on tobacco advertising expenditure or restrictions in countries outside the United States. Without any advertising expenditure data, he was unable to allow for the fact that advertising expenditure levels do not fall for long after partial bans because the advertising is soon re-channelled into unrestricted media.[4] Lacking data on advertising controls outside the United States, Hamilton included Japan as a country where advertising had been banned; a review of the history of tobacco control in Japan omits mention of any such restriction.[5] Italy was included, even though the ban was not enforced (see 8.5).

New Zealand was one of the countries Hamilton studied, and he concluded that the ban had no effect. However, because he only counted cigarettes, Hamilton was unaware that after cigarette advertising was banned on radio and television in March 1963, total tobacco consumption per adult peaked that same year.

Strangely, Hamilton did not include Iceland, the only country that prior to 1973, the end of the period studied, had banned tobacco promotion totally for health reasons (see 8.4).

Hamilton's was the first published international econometric analysis of tobacco advertising effects on consumption. Because the Hamilton paper was delivered to a world conference, because his work was partly supported by a grant from the American Cancer Society, and because of the nature of his findings, his work has been quoted widely and used by the tobacco industry in approaching various governments since.

This influential study, based on inadequate data, resulted in faulty specification of the problem. Hamilton found that partial bans do not work, but the implication was that bans and total bans probably do not work either. Since then total bans in several countries have been followed by falls in tobacco consumption, as discussed in Chapter 8.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Hamilton faced a problem yet to be addressed by international health agencies - of how to obtain sufficient multi-country information of tobacco industry expenditures on tobacco promotion, so that government policy action regarding tobacco promotion can be based on the best international data that money can buy.

7.3.2 The (British) Advertising Association (BAA) study

This study would appear to represent the official view of the British advertising world.[6] The BAA in London is well placed to document tobacco consumption and advertising in Europe, and the reasons for advertising bans. The BAA study, however, makes little if any distinction between bans for political, trade, or health reasons.

The 1981 edition compares trends in cigarette rather than tobacco consumption in Poland, Italy and Norway, and total sales at that, rather than consumption per adult. The BAA's rising graph of cigarette sales for Italy does not argue against advertising bans, but proves that when tobacco price halves, consumption rises (see 8.5). The rising graph for Poland only emphasises that advertising bans should be accompanied by other measures such as health education (see 8.7). The BAA study omitted to analyse for the effects of cigarette prices and per capita incomes when judging the effects of advertising bans. Thus, after consideration of a small fraction of the data available, the BAA concluded that advertising bans do not work.

The fifth edition of this paper published in 1984 and comparing 1970 with 1982, showed that manufactured cigarette consumption rose for a number of advertising ban countries. Omitted are the consumption trends for other forms of tobacco. Just as in Norway total tobacco consumption for smoking has been falling even though for some years the manufactured cigarette component continued to rise; manufactured cigarette consumption alone in most countries will not accurately indicate total tobacco consumption trends. In other words, rising cigarette consumption alone is not proof that an advertising ban is ineffective with regard to tobacco consumption.

Norway is given special attention. According to the BAA, tobacco consumption per adult in Norway has been drifting downwards since the first complete year of the Norwegian tobacco advertising ban (1976), and smoking in young women peaked in that year also.[7] Data of this nature argue that a total advertising ban is probably effective. The BAA, however, ignoring any such conclusions from its own published tables, and without mentioning any statistical analyses having been performed, concluded, 'There is no statistical evidence that the Norwegian tobacco advertising ban has affected in any way overall tobacco consumption'.[8] The BAA paper thus discounted the total advertising ban in Norway without due scientific enquiry.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

7.3.3 World Health Organisation (WHO) reviews of tobacco use

These WHO reports do not address the impact of tobacco promotion policies, but are mentioned here because of the confusion that can easily arise between the tobacco consumption data analysed in this Department of Health report, and the manufactured cigarette consumption data in the WHO and most other reports. The two data sets are complementary but not interchangeable. Conclusions based on manufactured cigarettes should not be used as if the two data sets are interchangeable. They are not.

The World Health Organisation,[9] the International Agency for Research on Cancer,[10] and, more recently, the European office of the World Health Organisation,[11] have tabulated cigarette production, consumption and smoking prevalence data for many countries. (For only a few countries in some years are tobacco consumption data supplied.) The data show that cigarette consumption is still rising in many countries, but that tobacco consumption has already peaked in most Western and many Eastern European countries (Appendix 3.2).

The reason lies in the fact that where hand-rolled cigarettes are popular (North Europe, Australia and New Zealand), tobacco consumption per adult reaches its peak a decade or so ahead of the peak in machine-made cigarette consumption (just as in many countries male smoking peaks some years ahead of ahead of smoking among women). Even where tobacco promotion has been outlawed, as in Iceland, Finland and Norway, manufactured cigarette consumption may continue to rise for a decade or so, as the smoking population shifts towards machine-made cigarettes, even though overall tobacco consumption is falling.

Fundamentally, public health concerns centre on tobacco, the toxic substance, not on manufactured cigarettes, yet tobacco consumption data are more difficult to obtain.

7.3.4 The International Advertising Association (IAA) 16 - country study

The New York based International Advertising Association's study of sixteen countries was a key document appended by the Tobacco Institute of New Zealand in its submission in response to the 1986 recommendations of the Toxic Substances Board to ban tobacco advertising. The study summarises its own purpose and findings thus:

> The IAA study serves a more modest if worthwhile purpose, namely to investigate whether advertising bans have been followed by decreases in overall tobacco consumption. The answer is NO.[12]

The IAA document merits close study, as many of the same arguments are likely to surface in any discussion in any country contemplating a legislated ban. The IAA study contains more data than the BAA study but has limitations:

- Although the document is all about tobacco advertising bans, no data on tobacco advertising expenditure are mentioned for any country before or after an advertising ban. Advertising expenditure data are crucial for evaluating the effects of a ban, as they show how soon advertising declines before a total ban, or how much, if at all, advertising expenditure declines after a partial ban.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

- The IAA consumption data are from trade sources or from the United States Department of Agriculture. As the references are general only, it is not possible to know which are USDA data and which are industry data.

- Researchers will find that the IAA data differ in some cases from official national statistics, in both consumption and population. Nor do the data necessarily correspond with data published in the Commonwealth Secretariat's *Tobacco Quarterly*.

- Policy makers looking for sound conclusions will be disappointed. In countries where advertising has been absent and smoking had increased since 1970, as in Eastern Europe, the IAA document concluded that advertising was not a significant factor.[13] This assumption was made without reference to prices or health education. For example, Russian cigarettes were cheap and smoking control measures virtually non-existent.[14] Total cigarettes smoked per adult in the USSR actually peaked in 1976.(see 8.7).

- Economists and public health professionals will find that tobacco promotion bans are considered by the IAA in isolation from other determinants of consumption. Tobacco price data were omitted in thirteen of the sixteen countries studied. (Price data were obtained for 25 out of 33 countries in the Department of Health's study.) As price is the best known determinant of demand, and tobacco price indices are published for almost all OECD countries, the omission of price data casts doubt on the seriousness of this study apart from lobby purposes.

  For readers who are policy makers, the omission of price can seriously mislead in the case of Italy. The halving of Italian tobacco prices relative to prices of other goods in the 1960s and 1970s can explain most of the growth in tobacco consumption in those years. Lack of enforcement of the advertising ban was also probably a factor (see 8.5), but the IAA simply concluded that 'the absence of almost all tobacco advertising over twenty years has not resulted in any decline in tobacco consumption'.[15] This statement assumes that advertising bans have to overcome all other contrary forces (including non-enforcement of the ban) to prove their effectiveness - an impossible test, which proves nothing.

- Per capita income, another well-known determinant of consumption, is omitted. Income data for these countries are readily available[16] but were given for only two out of sixteen countries (as opposed to income data obtained for all thirty-three countries in the present study.) This omission is misleading in the case of Iceland and Singapore, which, since banning tobacco promotion around 1970, have averaged nearly 4 to 5 percent annual real income growth per capita (Appendix 3, Table A3.1), sufficient to raise consumption by 2 percent per year.[17] Against such income effects, *any* decrease in consumption indicates a powerful lowering effect on consumption from either price increases, health publicity or an advertising ban.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

- Teenage smoking in advertising ban countr IAA booklet, thus failing to address the red young people in these countries (Table 7.5.

- In short, the data in the IAA brochure were are simplistic, unjustified, erroneous and mi

7.4 Methodology of Department of Health's study

In an effort to avoid the deficiencies in previous stu Health's study:

1. Includes 33 countries

- All OECD countries were included. Singapo been cited as a ban country by the IAA, mak market economies for study.

- The nine Eastern European centrally planned is not permitted, countries included in the IA the period 1980-86. Data on consumption be

- The IAA had included two developing countr which restricted tobacco advertising from abo excluded, due to lack of data on handmade cig Thailand, manufactured cigarette consumption decreased since 1983.[18,19] In Taiwan,cigarette along with increased tobacco advertising.[20,21,2

2. Spans a 16-year period

This study covers the period 1970-1986.

- In 1970 no advertising controls for health reaso advertising controls included warnings on ciga quarter of the thirty-three countries in the prese

- By 1986, thirty-one of the thirty-three countries warnings on packets.[23]

3. Relies on official data

Data sources are listed in Appendix 6. Tobacco trade jo consulted, as well as scientific and health reports on sm countries.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

4. Defines 'advertising ban' on a 10 point scale

A ban can cover one medium or all media. Each country was scored for each year, on the basis of published smoking control legislation[24] and supplementary information referenced in Appendix 6. The scoring system as detailed in Appendix 5 allots 0 for no controls and a maximum of 10 for elimination of advertising, sponsorship and 'indirect' advertising, accompanied by strong rotated packet warnings. The average scores for each tobacco promotion policy group of countries for the years studied were then calculated. Singapore, classified as a 'ban-country' by the IAA, allowed sponsorship, indirect advertising, some point of sale advertising, had weak packet warnings, scored only 6.5, placing it among strong partial ban countries. (See 8.6)

5. Uses a reliable consumption measure

- Consumption of all tobacco for smoking is measured

Any kind of tobacco for smoking is a toxic substance from the point of view of this report, and total tobacco consumption for smoking, rather than just its manufactured cigarette component, has therefore been measured for every country, as data permitted. Manufactured cigarettes make up almost all the tobacco smoked in Japan, but less than half in Norway. Tobacco for hand-rolled cigarettes are listed under loose tobacco in New Zealand, which is less than 10 percent of all tobacco consumed. Tobacco for hand-rolled cigarettes is counted under smoking tobacco in Scandinavia, and as cigarette tobacco in the United Kingdom. After excluding snuff (snuff use is common in Sweden and the United States), all tobacco products used for smoking were counted. In Iceland, total tobacco was counted, as non-smoking tobacco could not be excluded.

In a few countries, trade in cigars and cigarette tobacco and cigars was insignificant and not reported, and so for these products only, in-country production data were taken as the consumption measure.

Tobacco consumption data, in preference to only cigarette consumption data, were obtained from twenty-eight out of thirty-three countries,(exceptions: Albania, Bulgaria, Japan, Romania and the USSR) as opposed to only four out of sixteen countries in the IAA study.

- Excludes countries where handmade cigarettes confuse the picture

Handmade or indigenous cigarettes are rarely seen in developed countries, but in many parts of Asia, handrolled cigarettes are the dominant form of smoking tobacco. Lacking data on this important consumption fraction, it was decided to exclude Thailand and Taiwan from this study. For the Soviet Union, data include *papyrossi*, a popular variety of cigarette with a hollow mouthpiece.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

o Allows for supply factors

In centrally planned economies, consumption is predetermined by the five-year plan. Within this planning framework, shortfalls may occur. The lack of data on tobacco prices and supply problems in Eastern Europe since 1980 makes it difficult to determine if the fall in consumption in these countries is really due to the absence of advertising (see 8.7). Equally, the rise in consumption noted since 1970 in these countries by the IAA may have been due as much to gradual improvements in the supply of cigarettes or rising personal incomes as to unexplained increases in demand.

o Allows for distortions in recorded consumption

Consumption figures in several countries with strong advertising controls may have been elevated artificially. Between 1975 and 1985, tourist arrivals in Singapore increased by 2 million a year, or 191 percent, to exceed resident population;[25] each adult tourist is entitled to buy a carton of duty-free cigarettes. Tourist arrivals in Iceland also increased in this period, but to a much lesser extent,[26] while in Italy customs controls on smuggling have been tightened.[27] Although official statistics attempt to allow for these effects wherever possible, tobacco advertising ban effects can be underrated if official statistics due to tourism or changed controls on smuggling do not reflect the consumption of residents.

o Tobacco consumption *per adult*

For all thirty-three countries in this study, consumption data were calculated on a per adult (age 15 years and over) rather than a per capita basis (tobacco and alcohol consumption are traditionally calculated per adult). In the IAA study, per adult consumption was given for only six out of sixteen countries. Further, a per adult figure is more reliable when it is realised that many countries have lowered their birthrates dramatically over the 1970 to 1986 period. In these lowered birthrate countries, consumption figures per capita (per man, woman and child) can hide real falls in *per adult* tobacco consumption.

o Percentage of adults who smoke

For twenty countries trend data on adult (cigarette) smoking was obtained. Some countries have surveyed slightly different age groups and over different time periods. No attempt was made to age standardise these populations. Instead, countries were grouped according to their tobacco promotion policy in the years surveyed, and the average percentage change in adult smoking prevalence calculated according to tobacco promotion policy.

o Percentage of young people who smoke

The percentage of young people who smoke depends very much on the age of the group surveyed. Trend data for a uniform age group could not, unfortunately, be obtained for all countries. This problem was partly avoided by comparing age groups of approximately comparable ages and

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

by comparing the *annual percentage rate of decrease* in smoking over the period in each age group studied.

The present study has drawn data from existing surveys of the smoking practices of young people in their late teens or early adulthood: of 18-year-olds and, where possible, 15- to 24-year-olds. Smoking prevalence at the older ages is more indicative of adult prevalence in general. Within these limitations, repeat survey data on (cigarette) smoking in young people were obtained for eighteen countries.

- Income per capita

Total annual retail spending or value of sales in all stores in each country in millions of local currency has been used wherever possible in this study as the best guide to the general spending power in people's pockets. The value of retail sales published as an index standardised to 1980 prices[28] was converted to a per capita index. Where retail sales were not available, private consumption per capita at 1980 prices[29] was used and adjusted to a per capita index. For Portugal, in the absence of other data, the hourly wages index was used. Disposable income per capita was not used, as it was only available in a few countries. Indices (see Appendix 3, Table A3.1) are based on a 1980 value of 100 and are not standardised to allow inter-country comparisons of actual values, only of trends.

- Real tobacco price

Tobacco prices were converted to a tobacco price index, based on a 1980 value of 100, and the real price was obtained by dividing this by the consumer price index and multiplying by 100. National yearbook and monthly abstracts of statistics supplied most of these indices and, where necessary, were calculated from national accounts (see Appendix 5). This ensured that tobacco prices in each country were corrected for inflation. These price indices have not been standardised to allow inter-country comparisons of actual prices, only of trends.

- Cigarette price as a fraction of per capita income.

Inter-country comparison (as in the figures in Chapter 8) is based on the *affordability* of tobacco products, for which a price-divided-by-income score was constructed: the price of a packet of 20 cigarettes was calculated in 1980 US dollars, multiplied by 10,000 and divided by per capita annual income in US dollars. The answer measures (the inverse of) affordability. (Affordability of tobacco is controlled by government through tobacco taxation.)

7.5 Results

The overall finding of this study was that:

When countries were grouped according to the degree of governmental restriction of tobacco promotion, the greater the degree of restriction the greater the average annual fall in tobacco consumption. This was also true for the rate of decrease in the percentage of adults and young people who smoke.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

7.5.1 Policy on tobacco promotion in relation to tobacco use

1 Annual tobacco consumption per adult

Consumption varied according to the tobacco promotion policy in force during the years studied (Figure 7.5.1c, Table 7.5.1c).

More specifically, tobacco consumption per adult:

- Fell most rapidly in the total-ban group of countries where the ban had been implemented for health reasons.
- Fell next most rapidly where tobacco promotion had been banned for political reasons.
- Fell less rapidly in the group of countries where tobacco was promoted in a few media.
- Fell only slightly in the group of countries where tobacco was promoted in most media (examples: most OECD countries).
- Increased markedly in the group of countries where tobacco was promoted in all media (examples: Greece and Spain)(Table 7.5.1c).

2 Rate of change in the percentage of adults who smoke

Trends from repeat surveys were obtained from twenty out of the thirty-three countries (Table 7.5.1a). The results confirm the tobacco consumption data.

The percentage of adults who smoked reduced most rapidly in those countries *as a group* which had totally banned the promotion of tobacco, next most rapidly in the group of countries where tobacco promotion was limited to a few media, and much less rapidly in the group of countries where tobacco promotion was widely or fully permitted. The percentage for the 'promotion permitted in all media' group is slightly higher than for 'permitted in most media', but the result for all media is based on one country only.

The difference between the total ban and no controls groups was a 2.5 percentage points acceleration in the rate of reduction in smoking prevalence, attributable to the total ban policy option.

3 Rate of change in the percentage of young people who smoke

Eighteen of the thirty-three countries yielded repeat survey results (Figure 7.5.1b and Table 7.5.1b). The eighteen countries showed a clear difference in rate of reduction of smoking - that is, between those seven countries totally banning or strongly restricting tobacco promotion, and eleven countries not doing so. The difference between a total ban and promotion in all media is 2.7 percentage points in the rate of change per year. This is the difference to young people's smoking that government policies on tobacco promotion can make.
Since 1970, those countries with total bans have seen the proportion of youth who smoke lowered an average 2.8 percent per year, as against an average 1.6 percent in countries with tobacco advertising permitted in most media (Table 7.5.1b).

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Some of the decrease in teenage smoking in ban countries may be due to health promotion, or to price policy. This study shows, from both longitudinal and cross-sectional data, that when the curbs on tobacco promotion are strong, the reduction in smoking prevalence is more rapid.

4 Results of total ban versus promotion in all media

The total-ban-on-tobacco-promotion group of countries decreased their tobacco consumption. In the group with unrestricted advertising, consumption rose during the study period.

- The total ban countries averaged a -1.6 percent yearly decrease and the unrestricted advertising countries averaged a +1.7 percent increase, adding up to a total difference of *3.3 percent* per annum in the rate of change in tobacco consumption per adult (Table 7.5.1c), likely to be attributable, in part at least, to tobacco promotion policies.

Figure 7.5.1a Advertising controls and tobacco consumption per adult for 22 countries in 1986

Selection: The graph can only accommodate a limited number of countries. Included are all those for whom complete data was available.

Source: Statistical yearbooks of each country
National Accounts of UN and OECD
UN Demographic Yearbooks, World Health Statistics Annuals; Annual Digest of Health Legislation, 1970-86.
World Health Organisation.

- The 2.8 percent annual reduction in youth smoking achieved in three total ban countries (Table 7.5.1a) is a significant achievement. In New Zealand terms this is equivalent to the current 33 percent of 15- to 24-year-olds who smoke decreasing to 32 percent after a year and diminishing slightly less than this each year thereafter, as compared with the actual (negligible) fall of 0.16 percentage points per year since 1976.

5 Total bans versus partial bans

Total bans on tobacco advertising for health reasons are accompanied by annual average falls in tobacco consumption per adult of 1.6 percent per annum which is 4 times faster than in countries with partial bans. (Figure 7.5.1c).

The rates of decrease in the percentage of young people smoking are higher for the total ban countries and the strong partial ban countries (at -2.7 percent) than for countries where promotion is permitted in all or most media (Figure 7.5.1b).

6 Strong partial ban versus weak partial ban

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

The strong partial bans were accompanied by average annual decreases in tobacco consumption per adult that were no greater than for weak partial bans. *The average speed of decline in tobacco consumption for countries with a strong or weak partial ban was only 0.4 percent per year. Partial bans, whether strong or weak have weak effects. Compared with weak ban countries, the strong partial ban groups of countries saw more more rapid rates of decline in the percentages of smokers among young people and adults* (see Tables 7.5.1a,b and c).

Figure 7.5.1b Tobacco promotion policy and percentage change in youth smoking, in 18 countries

Source : Tables 7.5.1b and 7.5.1c, and official data from the countries concerned.

Figure 7.5.1c Tobacco promotion restrictions and percentage change in tobacco consumption per adult in 33 countries, 1970-86

Source : Tables 7.5.1b and 7.5.1c, and official data from the countries concerned.

Table 7.5.1a Annual percentage changes in the percentage of adults smoking in 20 countries, according to policy on tobacco promotion, 1970-86

Table 7.5.1b Percentage yearly reduction in the percentage of young people who smoke daily, in 18 countries, according to the tobacco promotion policy in force 1970-1986

Table 7.5.1c Trends in tobacco consumption per person age 15 years and over in 33 countries, according to tobacco promotion policy, 1970-86

7.5.2 Other factors influencing tobacco consumption

An often-asked question, and one obviously pertinent to any consideration of the impact of bans on the advertising and promotion of tobacco, is this: 'Why is it necessary to ban tobacco advertising when other methods of reducing tobacco consumption are available?' Apart from the question of principle (see 11.1), elimination of tobacco advertising by government is essential if *maximal* rates of decline in youth smoking are to be achieved. As Table 7.5.1b shows, Canada achieved one of the most rapid decreases seen internationally in the percentage of smokers amongst young people in the years 1970-1986. In 1987, however, the Canadian Government, wishing to be even more effective in protecting its young people from the risks of taking up tobacco smoking, brought in legislation banning tobacco promotion throughout Canada from 1989 on.

Another question is 'Can the differences in tobacco consumption trends between countries grouped by their tobacco promotion policies (see Table 7.5.2) be explained by any other factors apart from tobacco promotion policy? Can differences in price and income trends explain the differences? Adverse health

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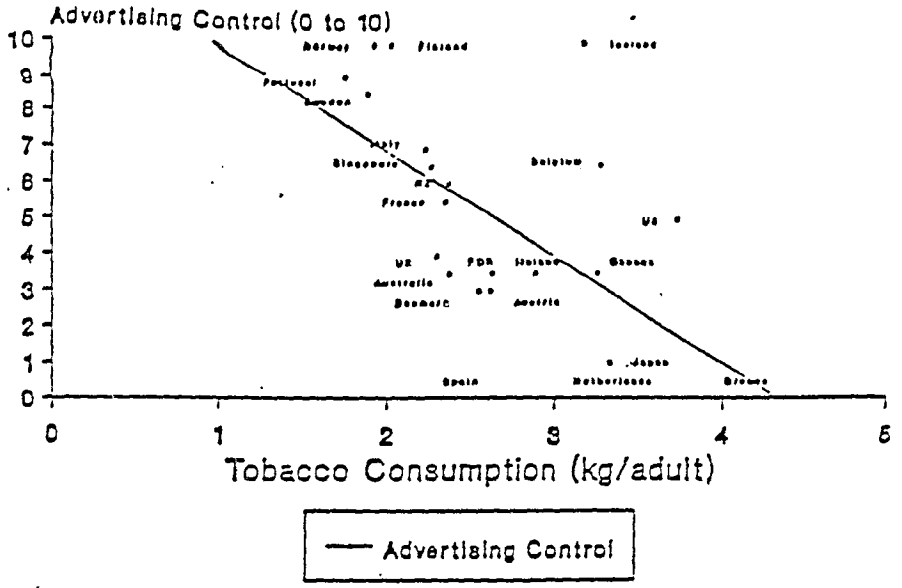
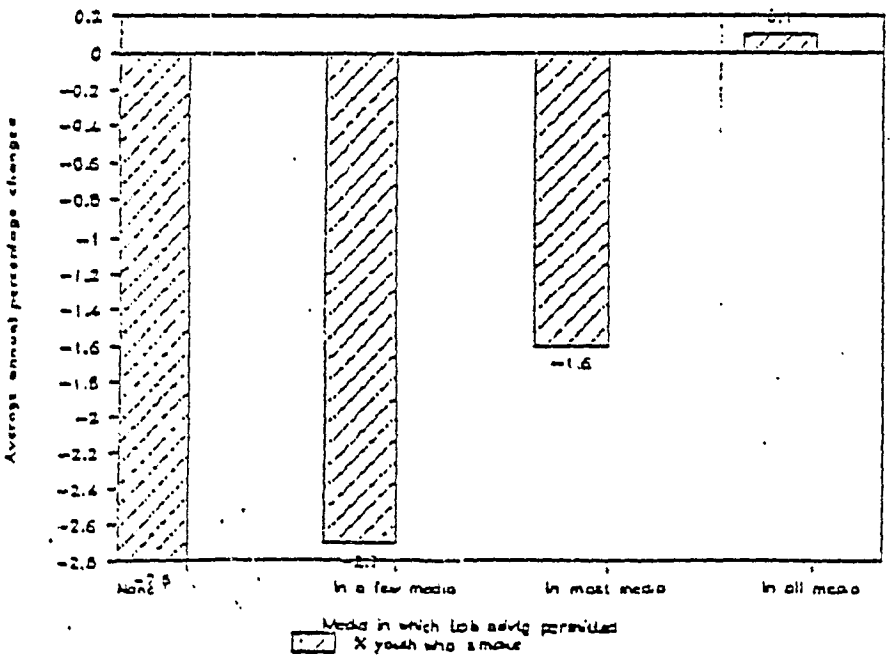
Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000



Source: Statistical yearbooks of the respective countries.
National accounts of UN and OECD.
UN Demographic Yearbooks, World Health Statistics Annuals.
International Digest of Health Legislation, World Health Organisation.

Fig7.5.1b Tobacco advtg. restrictions & % change in youth smoking, 19 countries



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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Country and year of ban	Age	Years reviewed	Percent smokers	Annual % change in percentage per country	per group of countries	
Enforced tobacco advertising ban						
Iceland 1972	18-69	85-86	40.0	36.2	-9.5	
Finland 1978	15-64	78-86	26.5	25.5	-0.5	group
Norway 1975	16-74	73-86	41.5	36.5	-1.1	average
Portugal 1983	na	83-84	na	23.5	na	-3.7
Promoted in few media						
Belgium	15+	80-87	41.5	32.0	-3.3	group
France	15+	76-83	44	39	-1.6	average
Italy enforced ban	14+	80-83	34.9	31.1	-1.3	-2.1
New Zealand	15+	76-86	35	30	-1.7	
Singapore#	15+	77-84	23	19	-2.5	
Sweden#	16+	76-85	38.5	29.6	-2.6	
Promoted in most media						
Australia#	16+	72-83	38.0	33.5	-1.1	
Austria	15+	72-81	28	27	-0.4	
Belgium	15+	70-79	20.2	21.3	+0.6	group
Canada	15+	70-86	45	32	-1.8	average
Denmark	15+	70-79	57.9	48.9	-1.7	-1.1
Fed.Rep.Germany	15+	70-84	41.7	36	-1.0	
France	15+	70-76	53.1	46.7	-2.0	
Ireland	15+	73-82	43	35	-2.1	
Netherlands	15+	70-86	58.5	38.0	-2.2	
Switzerland	15+	72-81	34.6	37.5	+0.9	
United Kingdom	16+	72-86	46	33	-2.0	
United States	17+	70-86	36.6	26.5	-0.6	
Promoted in all media						
Greece	15+	85		21.5	na	
Japan#	20+	70-86	46.6	37.6	-1.2	-1.2
Spain	15+	70-87	na	40.5	na	

Key # Male and female percentage averaged.
Selection All countries and periods for which data was published.
Sources: Rothwell, K and Masironi, R. *Cigarette smoking in developed countries outside Europe* WHO 1987.
Rothwell,K., Masironi, R. and O'Byrne, D. *Smoking in Europe*, WHO 1987.
Various other sources - see Appendix 6.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

countries, according to tobacco advertising policy in force

	age	years reviewed	percent smokers		change in percentage points p.a.	country average p.a.	
Tobacco promotion banned for health reasons							
Iceland	12-16	74-86	23	9	- 5.1		
Iceland	17-18	74-86	34	29	- 1.3	- 3.0	
Iceland	19-20	74-86	41	29	- 2.5		
Italy	15-18	72	51	na	na		
Finland	16	73-85	35.5	26.5	- 2.1	- 2.6	group
Finland	18	73-85	47	29	- 3.2		average
Norway	15	75-85	55.5	39.5	- 2.9	- 2.7	
	16-24	74-86	41	28.5	- 2.5		- 2.8
Portugal	20-24	83	46		na	na	
	15-24	na 87		45	na		
Tobacco promotion in few media							
Belgium	17	75-81	44.5	28.5	- 6.0	- 3.0	
Belgium	18-24	82-84	44	44	0		
France	14-16	76-84	29	25.5	- 1.5	- 1.95	
France	18-24	76-83	66	55	- 2.4		group
Italy	15-24	87		32.5	na		average
N. Zealand	15-19	76-87	30	27.5	- 0.8	- 0.8	
Singapore	15-19	84	na	4.8	na	na	- 2.7
Sweden	16	74-84	38	19	- 5.0	- 5.15	
Sweden	16-24	77-86	41	21.5	- 5.3		
Tobacco promotion in most media							
Australia	16-19	74-86	33.8	29.6	- 1.0		
Austria	14-29	72-81	30.0	35.0	+ 1.8		
Canada	15-19	72-83	31.7	20.3	- 3.3		group
Denmark	17-19	74-80	38.1	33.0	- 2.2		average
F R Germany	14-19	76-84	40.5	27.5	- 4.0		
Ireland	18	70-80	39	36	- 0.8	-2.4	- 1.6
	16-24	73-82	48	31	- 3.9		
Netherlands	15-19	70-86	56	22	- 3.8		
Switzerland	15-24	81		36.5	na		
USA	17-18	68-79	24.5	22.5	- 0.7		
UK	16-19	72-86	41	30	- 0.8		
Promotion in all media							
Japan	20-29	70-86	45	43.3	- 0.3		+ 0.1
Spain	15-24	81-87	53.5	55	+ 0.5		

Note: In all countries, the rate given represents both sexes. In most countries female and male rates were averaged.

Sources: Appendix 5
International Digest of Health Legislation. WHO.
Smoking and Health 1987 Excerpta Medica
Smoking in Europe WHO 1987
Smoking in developed countries outside Europe WHO 1987

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

publicity for example is known to encourage quitting.[30] Looking at Table 7.5.2, let us compare the two most extreme groups (total ban for health reasons, and tobacco promotion in all media). Tobacco consumption differs by 3.3 percentage points of annual change between these two groups. How can this change be explained? The income trends between the groups are much the same and cannot explain the difference in consumption. The annual trends in tobacco prices differ by 2.5 percentage points. The price elasticity for European countries on annual data is widely accepted as -0.4 to -0.5,31 which means that price trend differences can explain not more than 1.25 percentage points of change in tobacco consumption between the two groups, less than half of the 3.3 percentage point difference observed.

To explain the remainder of the 3.3 percentage points of annual change in tobacco consumption between these two groups of countries in Table 7.5.2, we are left with tobacco promotion policy differences. Although tobacco promotion bans have been accompanied by mandated health education in schools, this is unlikely to explain the changes in tobacco consumption in Table 7.5.2. The increased public awareness that might otherwise explain the changes in consumption between these groups of countries, is seen in countries with active anti-smoking groups, which tend to be those without total bans as yet.

Table 7.5.2 Summary of factors affecting the rate of change in tobacco consumption per adult in advanced economies, 1970-1986

Government policy on tobacco promotion	Average advertising control score level	Real tobacco price yearly change %	Real income per capita change %	Tobacco sales per adult, yearly change%
Total ban- health	9.4	+1.5	+2.1	-1.6
Total ban political	9.0	na	+ na	-0.4
Promoted few media	5.9	-0.5	+1.45	-0.4
Promoted most media	2.2	-0.05	+0.3	-0.4
Promoted all media	0.2	+1.7	+1.9	+1.7

Note: For the calculation of the advertising score, see Appendix 4.

Source: Appendix 5.

Tobacco price changes and per capita income growth are factors powerful enough to augment or weaken the net effects of advertising bans in certain individual countries, *but not enough to make the effect of advertising controls disappear when whole groups of countries are considered.*

Arguments based on one particular country (those against a ban will probably choose Finland, those for a ban will likely choose Norway) solve little. Data from just one country or even a series of individual countries do not prove or disprove that bans reduce consumption.

Grouping of countries by advertising policy, and knowledge of the effects of incomes and tobacco prices on consumption, enables conclusions to be drawn

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

1970-1986

Country and year ban enforced	Years studied from to	Tobacco consumption g/adult from	to	Change % p.a.	Country group Average annual change %
Total ban on tobacco promotion for health reasons					
Iceland[b] '72	72-86	3426	3326	-0.2	
Finland 1978	78-86	2087	2017	-0.4	- 1.6 percent
Norway 1975	75-86	2099	1919	-0.8	
Portugal 1983	83-86	2068	1750	-5.1	
Advertising never permitted for political reasons					
Albania[c]	80-86	1254	1183	-0.9	
Bulgaria[c]	80-86	2330	2282	-0.3	
Czechoslovakia	80-86	^2612	2374	-1.8	
E. Germany (FDR)	80-86	2403	2408	0.0	- 0.4 percent
Hungary	80-86	3420	3246	-0.8	
Poland	80-86	3529	3558	+0.1	
Romania[c,p]	80-86	2027	2071	+0.4	
Soviet Union	80-86	2106	2149	+0.3	
Yugoslavia	80-86	3269	3102	-0.9	
Tobacco promoted in few media					
Belgium	80-86	3323	3270	+0.5	
France	76-86	2352	2348	-0.02	
Italy	83-86	2306	2276	-0.4	- 0.4 percent
New Zealand	70-86	3115	2304	-1.6	
Singapore	70-86	2265	2261	-0.01	
Sweden	70-86	1921	1879	-0.1	
Tobacco promoted in most media					
Australia	70-86	3333	2375	-1.8	
Austria	70-86	2500	2615	+0.3	
Belgium	70-79	3436	3176	-0.8	
Canada	70-86	3990	3253	-1.2	
Denmark	70-85	2537	2542	+0.01	
FRG; W Germany	70-86	2678	2625	-0.1	- 0.4 percent
France	70-75	2181	2412	+2.1	
Italy	70-82	1816	2289	+2.2	
Ireland	70-86	3281	2887	-0.8	
Netherlands	70-86	3355	3021	-0.6	
Switzerland	70-86	3789	2865	-1.5	
United Kingdom	70-86	3377	2300	-2.0	
United States	70-86	3936	3187	-1.2	
Tobacco promoted in all media					
Greece	70-86	2570	3999	+3.5	
Japan[c]	70-86	2826	3329	+1.1	
Portugal	70-82	1451	2018	+3.3	+ 1.7 percent
Spain	70-86	2346	2644	+0.8	
Turkey	70-86	2064	2020	-0.1	

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Key	$_{c}$ manufactured cigarettes only $_{p}$ production not consumption $_{71}$ refers to 1971 data. $\hat{}$ 1981 data $_{t}$ total tobacco, including oral tobacco.
Note	Countries which changed their tobacco promotion policy over time, appear in more than one group. Tobacco is counted in pieces or grams.
Sources :	See Appendix 5. *International Digest of Health Legislation* WHO *UN Demographic Yearbook* United Nations *Tobacco Quaterly* Commonwealth Secretariat, London PN Lee *Tobacco consumption in various countries* Tobacco Advisory Council, London 4th edition, 1975. U.S. Department of Agriculture Economic Research Service, Tobacco circulars.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

about the effects of advertising policies. The overall conclusions of this study are robust, and will not be upset by including or omitting one country.

7.5.3 Advertising policies and the free flow of information

o Summary

A key argument in favour of advertising is that it is said to aid the transfer of information. Apart from the obvious lack of information in most tobacco advertising, could an advertising ban actually be harmful, by slowing down the adoption of less dangerous types of smoking?

The International Advertising Association takes the view that 'Tobacco advertising bans tend to prevent or hamper the spread of information about new features such as filtered and lower-tar cigarettes'.[32]

Insofar as product innovations appear to act as alternatives to quitting smoking, which outweigh any other positive features, the Board considers that the IAA claim is not supported by the available evidence, and rejects it.

As this matter has already been the subject of comment in the media, the dangers of quoting favourite countries should be noted. (For example, Poland, which has no cigarette advertising, has been quoted as a country where only 45 percent of cigarettes were filter-tipped in 1982 - one of the lowest.[33] But the growth in market share of filter-tips almost doubled from 1973 to 1982 - the highest growth rate for filter-tips of any developed country.[34]) To avoid this problem, the Department of Health study has reported on the *rate* of change in adoption of filter cigarettes in thirty countries grouped according to the tobacco advertising policy in force.

This review of thirty developed countries from 1973 to 1982, shows that countries which have banned tobacco products for health reasons, that is Norway and Finland, the average tar yield per cigarette in 1988 was under 15 mg, as least as low as in most other health- conscious countries. In total-advertising-ban countries filter-tips tripled their share of the cigarette market compared with countries permitting tobacco advertising.
In fulfilling its duty to ensure that the consumer is informed about the hazards of tobacco products, government does not, of course, have to rely on the tobacco manufacturer's advertisements (see 12.1(5)). Health education inserts in tobacco packets can be mandatory.[35] Finland has regulated against high tar cigarettes, and the Commission of the European Communities recommended a 15mg limit beginning 1989, and recommended it be lowered further in 1992.

Advertising bans and the shift to filter cigarettes

The experience of other countries is instructive regarding the question of advertising policy and flow of information.

o Norway's experience is that the change to filter-tips was primarily driven by health concerns, and the elimination of tobacco advertising did *not* slow or prevent market shifts towards manufactured (see 8.2.4), filter or low tar cigarettes.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Filter cigarettes as opposed to non-filter increased their popularity in Norway from 62 percent of manufactured cigarettes in 1973 - before the ban in 1975 - to 91 percent in 1982. In Sweden, in the same period, where tobacco advertising was still permitted in several media, filters increased market share from 79 percent to 92 percent.

Review of published data from thirty countries[36] shows that between 1973 and 1982 filter tip cigarettes increased their share of the manufactured cigarette market three times more rapidly in total ban countries than in countries where cigarettes were advertised.

Table 7.5.3a Annual average growth of the market share of filters in 30 developed countries, 1973-82

	Increase, annual average %	Number of countries
Total ban for health reasons	+ 3.1	2
Countries with total ban for whatever reason	+5.0	8
Advertising permitted	+ 1.7	22

Source: US Department of Agriculture 1983, quoted in *Tobacco Smoking*, Monograph no. 38, International Agency for Research on Cancer, 1986, calculated from Table 8, p.59.

Advertising bans were clearly in these years associated with an increased rate of shift from plain to filter-tip cigarettes.

In Norway and Finland, where tobacco advertising was banned for health reasons, filters increased their share of the cigarettes sold more rapidly than in other developed economies where cigarette advertising was permitted.

Consideration all the eight total ban countries in Europe for which data were available, filters' share of the cigarette market grew on average in each of these countries at 5.6 percent per year, compared with 1.7 percent per year in countries where cigarette advertising was permitted (Table 7.5.3a). In a different time period, it seems likely that the figures might have been different.
Adoption of filter-tips appears to be rapid between 20 and 90 percent of the market share, and slower above and below this range. Different countries pass through this rapid adoption phase in different years, and advertising bans have no apparent influence on it, one way or another.

Whatever the factors behind the more rapid and *rising* adoption of filters in cigarettes in ban countries, the proposition that advertising bans *slow* the shift to filter-tips or to low tar cigarettes can be confidently rejected for the period reviewed.

Filters not only fail to protect the smoker from heart disease,[37] they are associated with countries where there are more cigarettes smoked per smoker per day.[38] This may be purely an income effect: filter-tip cigarettes initially cost more than plain. Moreover, in many countries today, cigarettes are either filter cigarettes or hand-rolled. Plain cigarettes are much less common than before. The increased

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number of cigarettes smoked per smoker in countries where filter-tips are popular may merely reflect the fact that manufactured cigarettes are more convenient to smoke. Far more manufactured than handrolled cigarettes are smoked today in developed countries, and therefore manufactured cigarettes, usually filter-tipped, whether low tar or not, almost certainly cause more deaths than hand rolled cigarettes in these countries.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Table 7.5.3b Advertising restrictions in relation to the change in filter-tips' market share of manufactured cigarettes sales, 30 advanced economies, 1973-1982

Country and ban year	Percentage filter-tip 1973	1982	Annual increase %	Average increase%
Total ban on tobacco advertising, for health reasons				
Iceland 1972	na	na	na	group
Finland 1978	90	98	1.0	average
Norway 1975	62	91	5.2	+3.1%
Total ban on tobacco advertising, for political reasons				
Albania	na	na	na	
Bulgaria	70	70	0	
Czechoslovakia	48	90	9.7	
German Dem. Rep	na	na	na	group
Hungary	50	80	6.7	average
Poland	23	45	10.6	+5.6%
Romania	na	na	na	
USSR	20	30	5.6	
Yugoslavia	88	97	1.1	
Strong ban: cigarettes only promoted in a few media				
Belgium 80-86	68	84	2.6	
France 76-86	47	47	0	group
Italy 83-86	74	83	1.4	average
New Zealand	91	100	1.1	+1.85%
Singapore 1970	69	95	4.2	
Sweden	79	92	1.8	
Weak ban: cigarettes promoted in mst media				
Australia	93	95	0.2	
Austria	85	97	1.6	
Belgium	68	84	2.6	
Canada	90	95	0.6	
Denmark	50	60	2.2	
Fed.Rep.Germany	85	89	0.5	group
France	47	47	0	average
Ireland	78	88	1.4	+1.3%
Netherlands	50	67	3.8	
Portugal 1983	76	84	1.2	
Switzerland	96	97	0.1	
United Kingdom	83	94	1.5	
United States	85	93	1.0	
Promoted in all media				
Greece	79	92	1.8	group
Japan	96	98	0.2	average
Spain	51	90	8.5	+3.5%

Source: US Department of Agriculture 1983, quoted in *Tobacco Smoking*, Monograph no. 38, International Agency for Research on Cancer, 1986, calculated from Table 8, page 59.

Advertising bans and the shift to low tar cigarettes

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Data on tar yields were obtainable from two total ban countries, Finland and Norway.

Finland: Tobacco advertising was banned in February 1978. The percentage of smokers whose usual cigarette had a tar yield of less than 10mg increased from 0 in 1978-79 to 46 percent in 1983-85, a spectacular increase.[39]
Norway: In Norway where no tobacco advertising has been permitted since 1975, cigarettes on average in 1988 yielded 13mg tar.[40]
Sweden permits tobacco advertising. The average tar yield in 1988 was higher than in Norway, at 15mg.[41]
New Zealand: Norway's average tar level is also less than is found in the popular brands of manufactured filter cigarettes in New Zealand, a country where tobacco advertising is permitted.

Although in health-conscious countries the shift to low tar cigarettes is likely to be aided by advertising, as noted in 6.2.3 with reference to the United States, this does not imply that advertising is essential to such a shift. In countries where tobacco advertising is banned, government can still influence the smoker to smoke less tar per day:

- By requiring that all cigarette packets are printed to display tar yields.
- By regulating upper permissible limits for tar yields in all cigarettes. This is what has happened in Finland, and what the Commission of European Communities is proposing for Europe.[42]

Whatever the reasons, a ban on cigarette advertising in Norway and Finland has not slowed the shift to lower tar cigarettes, as compared with neighbouring Sweden or with New Zealand.

The notion that advertising bans actually do more harm than good by limiting the swing to low tar cigarettes, can be soundly rejected. On the contrary, as noted in 6.2.3, research shows that advertising promotions of low tar cigarettes increase overall cigarette sales. Low tar promotions on balance probably do more harm than good, by promoting a more dangerous alternative, given that most smokers want to quit.[43]

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7.6 Discussion and conclusions

The findings of the present study contradict claims published by the British Advertising Association and the International Advertising Associations that tobacco advertising bans are not followed by decreases in tobacco consumption.

The data from thirty-three countries support the view that the stronger the control of tobacco promotion, the more rapid the decrease in tobacco consumption per adult and in smoking amongst adults and youth.

Further, total tobacco consumption in countries which have banned tobacco promotion has fallen faster than in countries permitting tobacco promotion (see Tables 7.5.1a, 7.5.1b, 7.5.1c). Countries which have permitted continued tobacco promotion have achieved average falls inobacco consumption of 0.4 percent per annum since 1970, a glacial rate, implying that consumption in this group of countries could take another century at least to reduce to half of present levels.

As several advertising researchers have found, advertising can be regarded as giving rise to accumulated 'stocks' of goodwill in the public mind for the product. If these images are not 'topped up', by repeat advertising, the stocks eventually diminish.[44] A strong partial ban still permits the advertising stock of goodwill for the product to be maintained, for example, by sponsorship. A total ban stops this 'topping up' of goodwill stocks.

When a tobacco advertising ban for health reasons is accompanied by a fall in tobacco prices, the confounding effects of other factors such as tobacco price or per capita income can obscure, negate or overwhelm the expected fall in consumption from the ban. When countries are grouped by their tobacco promotion policy, the tendency for tobacco consumption to fall becomes clearer.

The findings from this study show unequivocally that tobacco consumption and use at different ages can be effectively decreased by government policies which ban tobacco promotion and raise tobacco prices.

The literature reviewed for Chapter 6, combined with the results above, indicate that the policy which lowers tobacco consumption most rapidly will combine a total ban on tobacco promotion with repeated tobacco price rises and repeated publicity on the health consequences of smoking.

Tobacco consumption increases when tobacco promotion is permitted and real price is allowed to fall; consumption declines markedly when promotion is totally banned and prices raised.

As noted in 7.5.2, the elimination of tobacco promotion remains an important factor, independent of other known factors, in explaining the differences in tobacco consumption trends between groups of countries. In other words, the elimination of tobacco promotion would appear to be influential in its own right, in reducing tobacco consumption. When the results of this study of thirty three countries between 1970 and 1986 are put alongside the evidence from econometric studies (Chapter 6) it seems more likely than not that, other factors being equal, the elimination of tobacco promotion *causes* a reduction in tobacco consumption and smoking prevalence to a level below what it would have been otherwise.

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For policy purposes, in the opinion of the Board, there is sufficient evidence from the thirty-three countries as a whole, and from the preceding chapters of this report, on which to firmly recommend the abolition of tobacco promotion as an essential part of a comprehensive policy to lower tobacco consumption.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

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8. REPORT OF A STUDY OF THE RELATIONSHIP BETWEEN GOVERNMENT TOBACCO PROMOTION POLICIES AND TOBACCO CONSUMPTION TRENDS IN 33 COUNTRIES : A CLOSER LOOK AT 15 COUNTRIES

Summary

The impact of the tobacco promotion policies of the fifteen countries selected here for closer examination indicate that (1) bans on tobacco promotion are associated with a lowering of tobacco consumption, and (2) bans on tobacco promotion show most effect when part of a total health policy package aimed at lowering tobacco consumption.

Iceland (in 1972) Norway (in 1975) and Finland (in 1978) implemented Tobacco Acts banning tobacco promotion and mandating health education. Tobacco consumption has subsequently fallen in each of these countries.

At the same time in these affluent countries personal incomes have continued to grow strongly in real terms. Tobacco prices were raised by taxation, but nevertheless, as a percentage of daily income, cigarettes now cost *less* than a decade ago. As a result, tobacco consumption has not fallen as rapidly since tobacco promotion was banned, as some might have hoped.

This is not to say that banning tobacco promotion does not work; quite the opposite, for the total bans on tobacco promotion in these Nordic countries have been very important in counteracting and curbing any tendency for tobacco consumption to rise substantially.

Iceland totally banned the promotion of tobacco in 1972, and its tobacco consumption peaked in 1975. Norway banned all tobacco promotion in 1975 and consumption peaked in that year. In Finland, tobacco consumption peaked in 1974. Portugal banned tobacco advertising in 1983 and consumption peaked in that year.

The percentage of youth (ages 15-24 years) who smoke has fallen more rapidly in Norway and Finland since the Tobacco Acts were passed, compared with New Zealand.

8.1 Introduction

The fifteen countries selected here for closer examination are essentially the sam ones reported on by the International Advertising Association (IAA). Thailand and Taiwan were excluded (adequate data not being obtainable), and New Zealand was added as the country of reference. Each country was re-examined using official and other data from sources independent of the IAA study.

For each country, the study examined, as best the data permitted, the complex interplay of health concerns, tobacco promotion, personal income trends and tobacco promotion restrictions, on tobacco consumption per adult, and on the percentage who smoke.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

8.2 Tobacco consumption and smoking in Norway

Summary

The Norwegian Government supported the 1973 Tobacco Act, which banned all tobacco promotion in Norway, by increasing tobacco taxation, and thereby making Norwegian cigarettes more expensive than previously. Although Norwegian tobacco prices were among the highest in Europe, Norwegian incomes were also high, and in the decade 1975-85 real incomes increased further, by 3.5 percent per annum. Tobacco prices did not rise enough to compensate, and cigarettes, as a fraction of daily income, actually became less costly. As a result, tobacco consumption per adult fell only gradually, about 8 percent in eight years.

Tobacco consumption was rising before the Act was introduced into Parliament, but thereafter decreased, particularly in young people.

The main advantage of the total promotion ban and other measures in Norway is that there is no way, short of changing the law, that tobacco can ever again be promoted so assiduously that consumption would substantially rise.

Figure 8.2 Norway - tobacco consumption trends

Sources Statens Tobakkskaderad, Oslo, 1987
Statistisk Manedshefte, Central Bureau of Statistics of Norway, to May 1988.
Main economic indicators Historical series, 1964-83; and *Monthly series* to 1988, OECD, Paris.

8.2.1 Government policy

The Tobacco Act was passed in 1973 and implemented from July 1975. It mandated health education, banned sale of tobacco to young people, and banned all tobacco advertising, sponsorship and indirect tobacco advertising (tobacco brandnames on other non-tobacco products).

8.2.2 Norway and New Zealand compared

- From 1975 until 1986, in Norway, reduction in the percentage of youth age 15-24 who smoked daily was ten times more rapid than in New Zealand (3 percent in Norway versus 0.3 percent reduction annually on average in New Zealand)(Table 8.2).
- Despite a higher per capita income than in New Zealand, the average Norwegian smoker in 1976 was smoking only about 13 cigarettes per day (compared with about 22 in New Zealand); he or she could afford to smoke more, yet did not.
- Norway, by acting early to curb tobacco promotion, avoided further development of the high rates in lung cancer death rates now seen in other countries. (Figure 4.2.1)

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Tobacco Consumption Trends

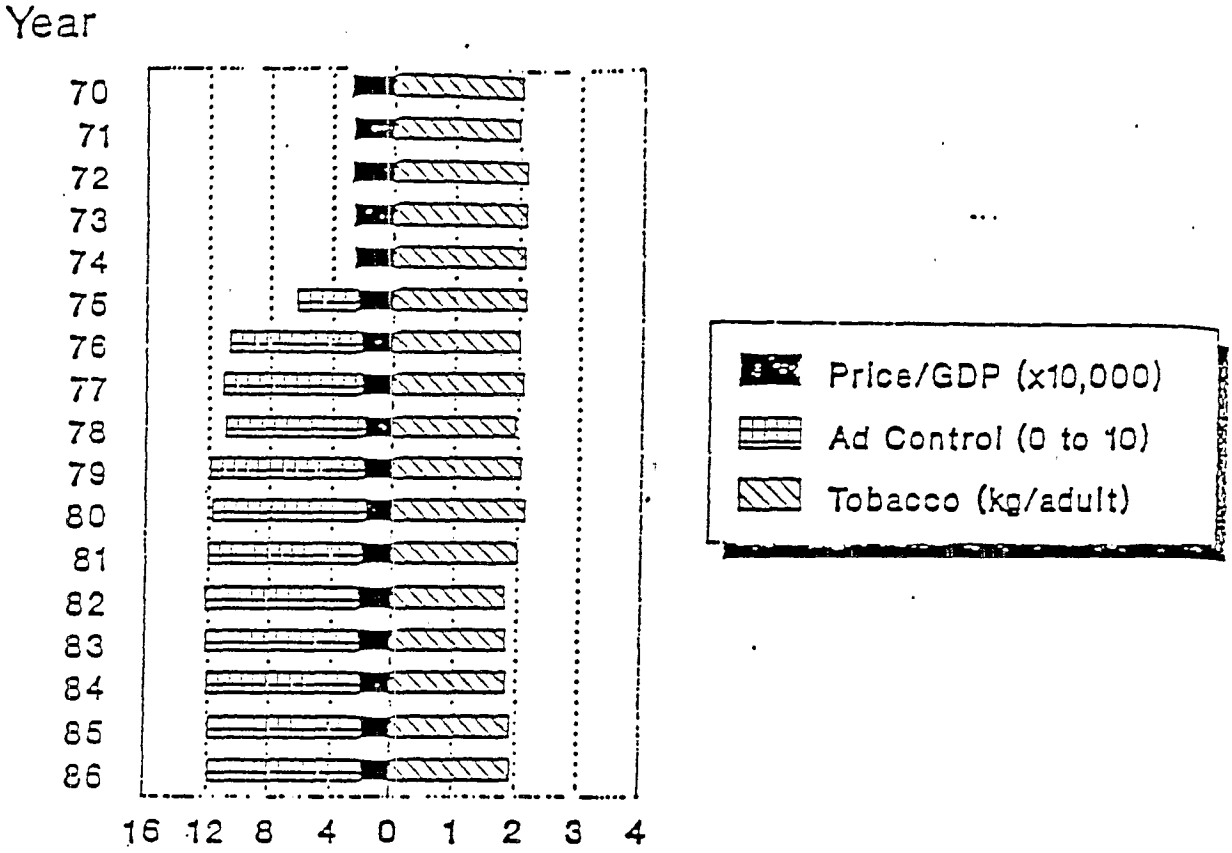

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Table 8.2.2 New Zealand, Norway compared for tobacco consumption and smoking, 1976-86

	NZ	Norway
Factors influencing smoking		
Tobacco promotion ban	partial	total
Tobacco advtg/cap. p.a.[a]	US$0.52	0.0
% change p.a.		
Real tobacco price index	+ 2.7	+ 1.9
Real GDP/capita	+ 1.5	+ 3.5
Outcomes, health consequences		
Tobacco consumption/adult	- 1.9	- 0.8
Daily smoking age 15-24	- 0.3	- 3.2
Daily smoking, adults	- 1.7	- 2.5
Lung cancer in women, 1985 ages 55-64, per 100,000 p.a.	73	40

Key [a] Press & magazines, 1979, in 1980 US$.

Sources: Norway: Table 8.2.1
New Zealand: *1976 Census* smoking question and for 1986, OTR Spectrum survey;
Consumption: *Monthly statistical abstracts*
Advertising . control score: Appendix 4.
GDP :*World statistics in brief*. 11th ed. United Nations, 1987.
Lung Cancer: *World health statistics, 1987*

8.2.3 Norway and the United Kingdom compared

A comparison of Norway with the UK, which has a partial tobacco advertising ban, with respect to how rapidly the percentage of youth who smoke has been falling in each country, shows that Norway has lowered smoking in youth more rapidly. Norway has achieved this despite the greater growth in Norwegian personal incomes, and without raising tobacco prices as rapidly as in the United Kingdom(Table 8.2.3).

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Table 8.2.3 Percentage changes in the percentage of young people smoking in youth, and factors affecting smoking, Norway versus United Kingdom, 1974-84

	UK	Norway
Tobacco promotion ban .	partial	total
Real tobacco prices	+ 2.6 %	+ 1.0 %
GDP per capita 1975-85	+ 1.8 %	+ 3.5 %
Youth, smoking daily	- 2.6 %	- 3.1 %

Sources: Norway: Statens tobakkskaderad Oslo, 1987, and Monthly Statistics and Yearbooks.
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GDP: *World statistics in brief* 11th ed. United Nations 1987.

8.2.4 Misrepresentation of the Norwegian situation

A rising cigarette volume sales graph for Norway was depicted as part of a full page advertisement in Canadian newspapers in 1988, placed by the tobacco industry to encourage opposition to legislation to eliminate tobacco advertising.

The advertisement omitted to mention that most Norwegian smokers use roll-your-owns, not manufactured cigarettes, and that sales of these were falling. Overall, tobacco consumption in Norway has declined since 1975 (Table 8.2.1).

Nor has the advertising ban interfered with the free flow of information or stood in the way of smokers switching to newer forms of tobacco products. Manufactured cigarettes nearly doubled in popularity following passage of the Tobacco Act, increasing their market share of all tobacco smoked from 29 percent in 1973 to 42 percent in 1986.[1] In the same period in Sweden manufactured cigarettes increased their share of all tobacco smoked from 85 to 87 percent.[2] With regard to filter and low tar cigarettes, Norwegian smokers have not been disadvantaged in any way compared with smokers in nearby Sweden, where advertising is allowed (see also 7.9).

The tobacco industry's 10-country 1988 survey of 15-year-olds included Norway and New Zealand and showed higher smoking rates in Norway than in New Zealand. This is not new information:[3] what is new, is that this study is being used to argue that a total advertising ban in Norway makes no difference to teenage smoking rates.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Year	1965	70	71	72	73	74	75	76	77	78
Tobacco g/yr[a]	1804	2040	1987	2117	2105	2086	2107	2020	2078	1957
Real cig. price[b]	118	110	119	117	119	116	112	112	106	na
Real retail sales[c]	72	86	88	88	86	90	93	99	103	94
Daily }16-74 m	na	na	na	na	51	53	48	49	44	45
smokers }16-74 f	na	na	na	na	32	32	33	32	30	31
percent }16-24 m	na	na	na	na	44	47	38	44	36	39
}16-24 f	na	na	na	na	42	43	39	40	37	36

Year	1979	80	81	82	83	84	85	86	87
Tobacco g/yr[a]	2047	2118	2007	1815	1832	1845	1916	1927	1870
Real cig. price[b]	108	100	113	126	130	129	129	133	138
Real retail sales[c]	99	100	101	99	97	97	107	112	106
Daily }16-74 m	43	42	40	40	42	42	42	39	na
smokers }16-74 f	33	30	31	34	32	34	32	31	na
percent }16-24 m	33	35	34	33	29	32	35	29	na
}16-24 f	37	36	33	37	31	31	34	28	na

Key
[a] Tobacco, pieces or grams released for sale per adult age 15+ years. 1 cigarette taken as 1 gram. Oral tobacco excluded.
[b] Real cigarette price index, base year 1980 = 100, deflated by consumer price index
[c] Real retail sales (all stores, all goods, constant prices) per capita index, base year 1980=100

Source
Statens Tobakkskaderad, Oslo, Norway.
Statistisk Manedshefte. Monthly Bulletin of Statistics. Central Bureau of Statistics of Norway, to May 1988.
Main economic indicators Historical series. 1964-83 and monthly series to August 1988.

2504065142

Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

To address this argument it is obviously necessary to know what the rates had previously been. Teenage smoking rates in Nordic countries in the early 1970s were high. Also longitudinal cross-country comparisons are necessary, and have been made - see Tables 8.2,1 and 7.5.1b. These show that youth smoking rates *have* fallen more rapidly in Norway, after advertising was totally banned, than in New Zealand (Table 8.2.2) or the United Kingdom, where it was merely restricted.(Table 8.2.3)

8.2.5 Results and discussion

For Norwegian tobacco consumption and smoking trends see Table 8.2.5. In Norway, tobacco consumption and smoking have reduced. Tobacco promotion is now a dead issue in Norway.

The Norwegian Smoking and Health Council's comments on the advertising ban after ten years are significant: 'In particular, the Council is convinced that the promising trends in the younger generation would not have been obtained without an advertising ban.'[4]

Table 8.2.5 Tobacco consumption and smoking in Norway

8.3 Tobacco consumption and smoking in Finland

Summary

Tobacco control policies in Finland have rather let their advertising ban, instead of taxation, control tobacco consumption. Taxation has raised tobacco prices slightly above inflation, but not enough to increase the price of cigarettes as a fraction of daily income (Figure 8.3). Personal incomes have been growing strongly, at around 3 percent per annum in real terms in the past decade. Consumption has fallen, but only gradually.

The slow decline of tobacco consumption is not desirable from a health viewpoint, but does not imply that government policy failed: the policy achieved exactly what was intended, that is, fulfilling the *economic* objectives of controlling inflation and protecting tobacco industry employment.

In association with the advertising ban, the percentage of youth smoking fell more rapidly in Finland than in New Zealand (Table 8.3.3).

Figure 8.3 Finland - tobacco consumption trends

Source Central Statistical Office of Finland, *Tobacco Statistics* 1985-87. Advertising control score: see Appendix 4.

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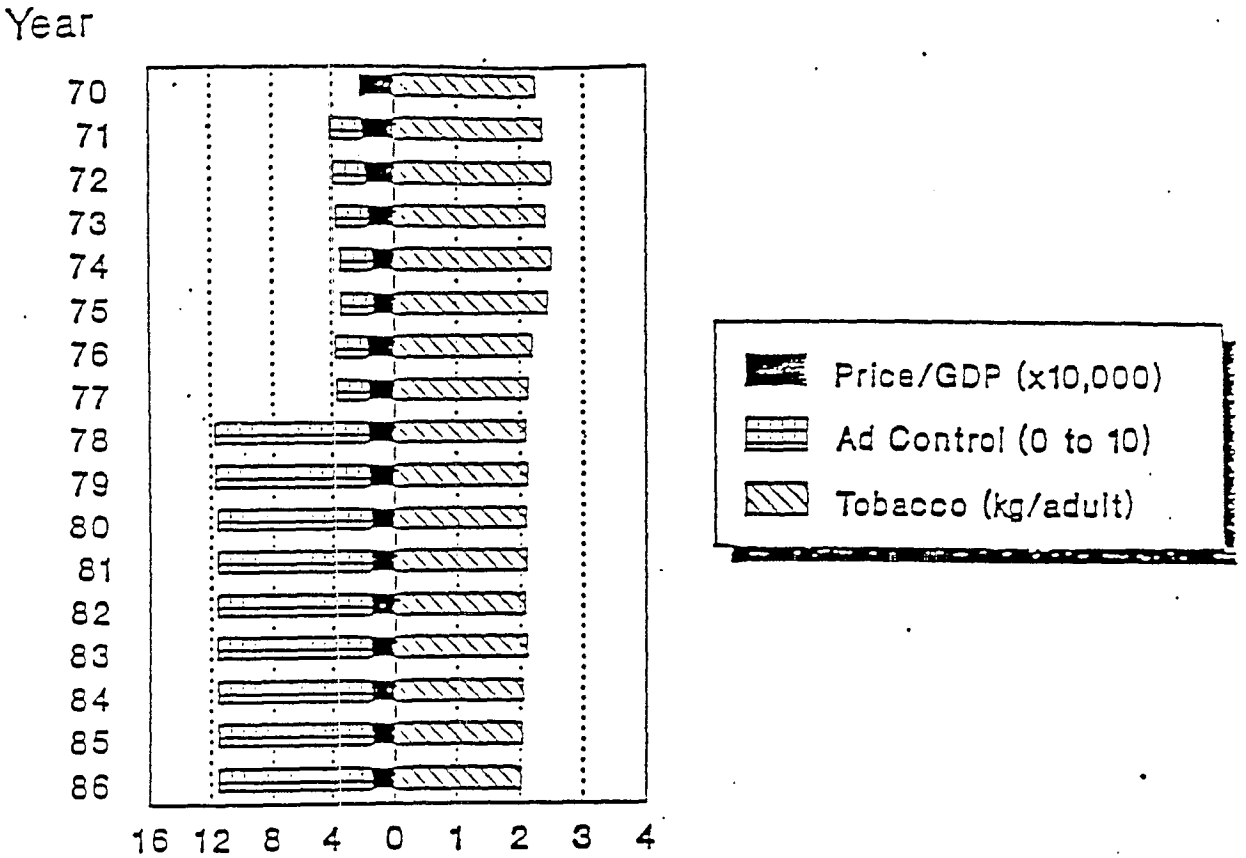
Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Fig 6.3 Finland
Tobacco Consumption Trends



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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

8.3.1 Government policy

The Finnish Ministry of Health first proposed legislation to ban advertising of tobacco products in 1975. The Tobacco Bill was introduced to Parliament in 1976, and was enacted in 1977, with the total advertising ban effective from February 1978 and health education mandated. The Act's passage was accompanied by price rises for tobacco products, strengthened health warnings on tobacco packaging and a ban on sales of tobacco products to children.

The total policy package of the Tobacco Act 1977 was designed to preserve employment in the tobacco industry and avoid inflation.[5] These policy aims were realised, along with a reduction in tobacco consumption.

8.3.2 Summary of findings

In Finland, since proposals (in 1977) were put forward and subsequent legislation came into effect in 1978 to ban totally the advertising of tobacco products:

- Smoking rates in teenagers have fallen by 8 percent in 14-year-olds, 7 percent in 16-year-olds and 22 percent in 18-year-olds, over the period 1977-85 (see Table 8.3.1).
- Overall tobacco consumption has dropped by 5 percent over ten years despite rising per capita incomes (Tables 8.3.1 and 8.3.2).

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Table 8.3.2 Smoking in Finland by age and gender, and tobacco consumption, 1973-86

Year	1973	75	77	79	81	83	85	86
Daily smokers %								
Boys age 14	18	na	11	9	15	15	13	na
Girls age 14	21	na	15	9	12	13	10	na
Boys age 16	39	na	30	25	30	27	28	na
Girls age 16	32	na	27	24	25	23	25	na
Men age 18	44	na	41	34	36	34	32	na
Women age 18	49	na	32	26	26	25	25	na
Men age 15-64	44	na	40	35	37	na	35	na
Women age 15-64	20	na	17	16	17	na	17	na
Tobacco/adult[a]	2405	2442	2128	2117	2108	2113	2034	2017
Real Tob.Price[b]	94	80	96	104	101	108	107	109
Income[c]	87	98	91	96	100	105	108	110

Key
a Tobacco consumption, pieces or grams per adult, November years.
b Real tobacco price index: base 1980=100.
c Income index based on total retail spending per capita in constant finnmarks: base 1980=100.

Note Surveys of smoking are biennial, excepting 1975.

Source : Central Statistical Office of Finland, Tobacco statistics, 1985-87.
Main economic indicators, 1963-83 and monthly to 1988, OECD 1985.
Rimpela, M. et al. *Health habits among Finnish youth: The Juvenile Health habit survey 1977-79*, and unpublished data for 1981-85. National Board of Health, Helsinki, 1983.

8.3.3 New Zealand, Norway and Finland compared

In reducing teenage smoking, Norway and Finland, with total bans on tobacco advertising, saw a more rapid rate of decrease. New Zealand, with a faster rate of increase in tobacco prices due to taxation, saw tobacco consumption fall more rapidly than in Norway or Finland.(Table 8.3.4)

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Table 8.3.3 Percentage change per annum in smoking : New Zealand versus Norway, versus Finland, 1976-86

	New Zealand	Norway	Finland
Tobacco print advtg. p.a.	NZ$4.3[a]	nil	nil[b]
Advertising control score av.	5.7	9.6	8.5
	% annual change		
Real tobacco price index	+ 2.7	+ 1.9	+ 0.8
Growth p.a. in real GDP/capita	+ 1.5	+ 3.5	+ 3.0
Tobacco consumption per adult	- 1.9	- 0.8	- 0.8
Daily smoking in youth[c]	- 0.3	- 3.2	- 2.7
Daily smoking, adults[d]	- 1.7	- 2.5	- 1.1
Lung cancer rate in women age 55-64, deaths per 100,000 p.a.	73	40	24

Key
a In millions 1988 dollars
b From 1978.
c Age 15-24 in NZ: ages 16-24 in Norway; age 18 in Finland, 1977-85.
d Age 15+ in NZ: ages 16-74 in Norway, in Finland age 15-64, 1977-85.

Source: Smoking prevalence: Norway Table 8.2.1, Finland Table 8.3.1, New Zealand 1976 Census and 1986 OTR Spectrum survey
Consumption: *Monthly statistical abstracts.*
Advertising control score: Appendix 5.
GDP growth *World statistics in brief* 11th ed. United Nations, 1987.
Lung cancer rates: *World statistics annual 1987.*

8.3.4 Results and discussion

Although tobacco consumption in Finland did fall following passage of the Tobacco Act in 1977, the decrease has not been marked: tobacco consumption per person aged 15 and over fell 5.2 percent from 1977 to 1986.[6]

Very few price increases for tobacco have occurred since passage of the Act, as the pricing policy of the Government has, in fact, been designed to avoid inflation and safeguard tobacco industry employment (cigarette prices have been raised no more than 5 percent per annum). This is not a weakness of the advertising ban, but a result of the fact that the Government's policy has been primarily to serve economic, not health, goals.[7]

Finnish health officials in no way want a return to the days of tobacco advertising, but advocate that an advertising ban should be supported with sufficient tobacco taxation to counteract the twin effects on consumption of inflation and rising incomes.[8]

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

8.4 Tobacco consumption and smoking in Iceland

Summary

Iceland has experienced annual growth rates of incomes of nearly 5 percent in real terms from 1970 to 1986.

Instead of income increasing consumption by 2.5 percent as might be expected, consumption has not increased. Consumption of tobacco per adult peaked in 1975, and has been decreasing since at 1 percent per annum.

8.4.1 Government policy

Iceland's 1971 Act banned all kinds of tobacco promotion from January 1972. A further Act that came into effect in 1985 required stronger packet warnings and tagged the equivalent of 2 percent of annual tobacco sales for anti-smoking education and activities.[9]

8.4.2 Summary of findings

After the total tobacco advertising ban came into effect in January 1972:

- Total tobacco consumption per adult peaked a few years beyond r the ban and then reduced fairly steadily thereafter (Table 8.4).
- Smoking rates among Reykjavik teenagers (note that 40 percent of Iceland's population lives in this city) fell dramatically (see Figure 8.4b).

8.4.3 Results and discussion

Women smoking

For younger Icelandic women, smoking, and now lung cancer rates, are higher than for men.[10]

Tobacco price

The fall in Icelandic tobacco consumption during the late 1970s was achieved despite a fall in the real price of tobacco over this period (Table 7.3). Tobacco may have become relatively cheaper due to unprecedented inflation since 1984 - general prices increased by 952 percent between 1980 and 1987.[11]

Income per capita

The fall in tobacco consumption since the late 1970s has been despite a dramatic rise in incomes: total personal private consumption (all goods and services) per capita in real terms (constant currency) doubled in 20 years.[12] Expressed another way, incomes in real terms rose by nearly 5 percent per year from 1970 to 1986, which should have raised tobacco consumption by nearly 2.5 percent per year.[13]

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Affordability

The price of 20 cigarettes, as a fraction of daily income per capita, decreased after 1978 (Figure 8.4a). The increased affordability has been associated with increased imports during 1984-86,[14] with most of the increase accounted for by lighter American cigarettes.

Figure 8.4a Iceland - Tobacco consumption trends

Sources : *Tolfraedihandbok: statistical abstract of Iceland*, 1974, 1984, Statistical Bureau of Iceland.
Tobacco Quarterly, May 1986, November 1988.
International Financial Statistics (IMF)
Advertising control score: Appendix 4.

Type of tobacco

As in other Scandinavian countries, total tobacco is likely to be a better guide to the health consequences of smoking than manufactured cigarette consumption. All tobacco is imported, and annual imports probably vary more than consumption. In type of tobacco smoked, hand-rolled cigarettes have lost market share to manufactured cigarettes, a trend which the advertising ban, as in Norway, has not interfered with.

Smoking in young people

For sixteen years, children in Reykjavik aged 12-16 have been exposed to health education, but not to tobacco advertising. They have been surveyed by anonymous questionnaire annually since 1974.[15]

The children surveyed in 1988 had lived all their lives free of tobacco advertising pressure and were found to smoke much less than children of their age in previous years. The results are similar to those seen in Norwegian teenage smoking rates since the Norwegian advertising ban in 1975 (Figure 8.4b).

Figure 8.4b Percentage of 12- to -16-year-olds who smoke, Reykjavik, 1974-86.

Source: Magnusson S. et al. Smoking habits of schoolchildren in Reykjavik, Iceland. 1974-86. In M.Aoki et al. eds. *Smoking and health 1987*. Elsevier Science Publishers BV., 1988, p.548.

While recent surveys indicate many Reykjavik teenagers are still smoking, more are not taking up the habit till later. This will decrease their risk of lung cancer, for which the risk rises steeply according to the number of years smoked.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

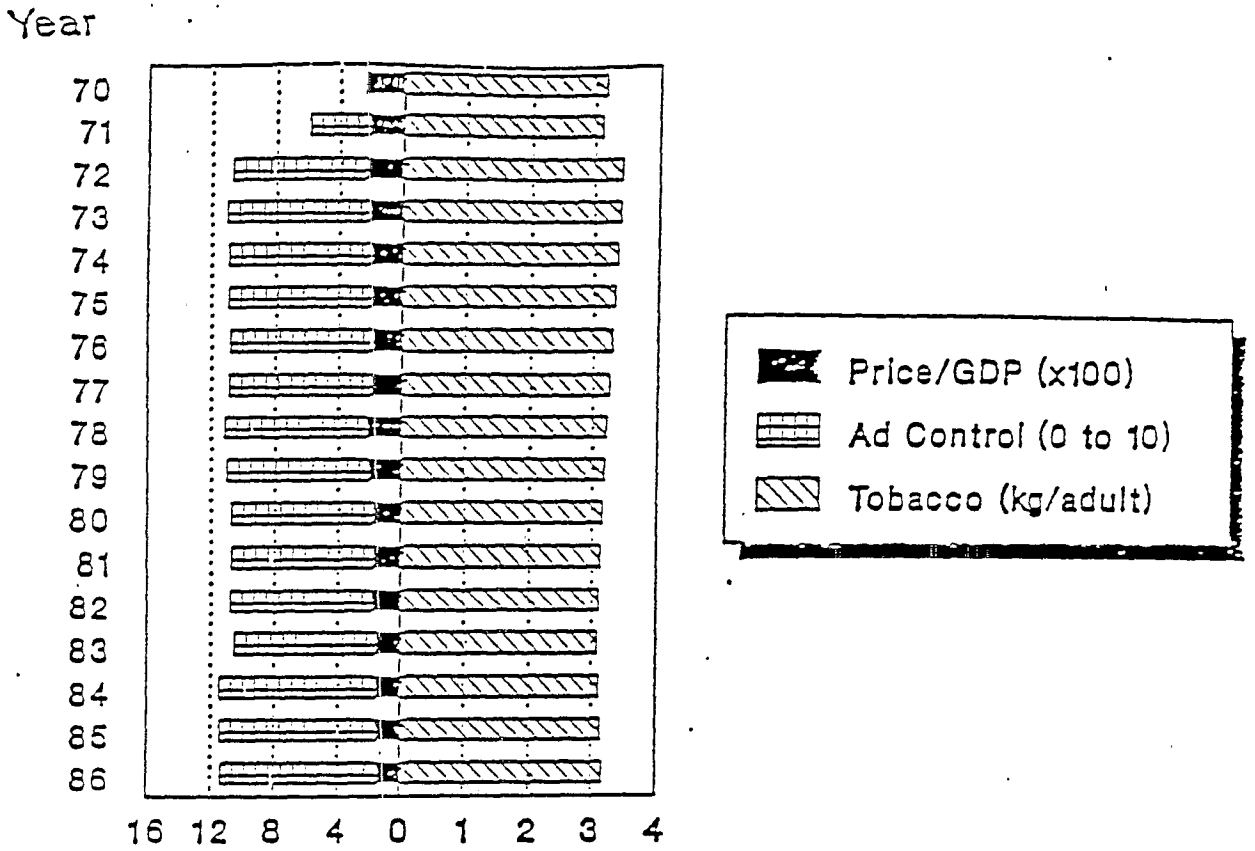
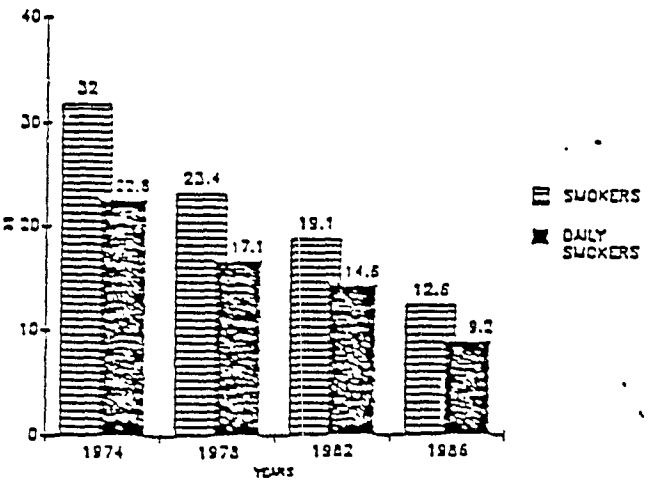


Fig 8.4b Smoking habits of children in Reykjavik, age 12-16



Source: Magnusson S, Ornolfsson T. and Johson S. Smoking habits of school children in Reykjavik, Iceland 1974 to 1986. Smoking and Health 1987. M. Aokoi et al, editors. Elsevier Science Publishers. B.V. 1988 p.545

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Table 8.4. Total tobacco consumption per person age 15+ years in Iceland

	1960	1965	1970	1975	1980	1985	1986	1987
Tobacco g/adult[a]	2421	2952	3175	3782	2757	3422	3326	3106
Ad. controls[b]	0	0	0	9	9	10	10	10
Real cig. price[c]	87	82	84	86	100	na	na	na
Income per capita[d]	48	60	66	89	100	na	na	na

Key
a Tobacco consumption includes snuff and chewing tobacco
b Advertising control score: Appendix 4.
c Real cigarette price index: base year 1980=100
d Private consumption all goods & services index/capita constant currency: base year 1980 = 100

Sources *Tolfraedihandbok, statistical abstract of Iceland* 1974, 1984, Statistical Bureau of Iceland. *Tobacco Quarterly.*

8.5 Tobacco consumption and smoking in Italy

8.5.1 Government policy

The 1962 Act was at a time when health concerns about tobacco were only beginning to attract publicity. The Act may have been intended to protect the position of the state tobacco monopoly. Increasing health concerns lead to a tightening of the law in 1983.

8.5.2 Results and discussion

To understand better the unusual situation in Italy, the reader is referred to a chronology of the relevant events:

1962	Tobacco advertising banned. The law is weak (fines only US $130) and widely flouted.[16]
1963-74	Tobacco prices in the shops remain virtually unchanged. Tobacco prices are almost halved relative to other goods, incomes increase and tobacco consumption almost doubles[17] (Table 8.5.3).
1975	Tobacco prices are increased for the first time since 1963 (Table 8.5.3).
1980	Tobacco consumption per adult falls (Table 8.5.3).
1981	Tobacco prices increase faster than inflation.
1983	National health survey data show decreased smoking in all age groups, including youth, since 1980.[18]
1983	Italy passes a stronger advertising ban law, with fines equal to millions of US dollars.[19] Indirect advertising is still permitted; tobacco brandnames appear on clothing, shoes, perfumes, handbags, etc.[20] Health warnings on tobacco packets remain weak.
1986	Total tobacco sales decrease (Table 8.5.3).
1987	Prices rise and tobacco sales decrease further.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

1970-87 Cigarettes remain more affordable than in most other countries in Europe, as judged by the price of twenty cigarettes as a fraction of income, which remains extremely low.(Figure 8.5)

Figure 8.5 Italy - Tobacco consumption trends

Source *Annuario statistico Italiano.* Instituto di Statistica
Bolletina Mensile statistica, May 1988.
International financial statistics. IMF.
Advertising control score: Appendix 4.
UN *Demographic Yearbooks.*

8.5.3 Summary of findings

The experience of Italy, then, from 1962 to 1975 demonstrates that a tobacco advertising ban which is not enforced cannot be expected to control tobacco consumption, and even more so, when tobacco which is already cheap, becomes relatively cheaper and more affordable each year (Figure 8.5). Italy's experience since 1983, when a stronger advertising ban was introduced along with an increase in tobacco price, has been more positive.

The clear message to come out of the Italian experience is that any law to eliminate tobacco advertising should:

- o be strictly enforced;
- o eliminate 'indirect' tobacco brandname advertising (i.e., on non-tobacco goods) - when permitted, indirect advertising can become a widespread and established practice, effective in keeping brand images alive, but difficult to eliminate at a later date;
- o be part of a comprehensive policy approach to lower consumption.

Table 8.5. Italy - tobacco consumption, price and income

Year	1960	70	75	80	83	84	85	86	87
Real tob. price[a]	244	191	121	100	117	114	114	116	120
Real income/cap[b]	na	75	88	100	102	112	96	99	102
Tobacco/adult[c]	1658	1816	2517	2262	2306	2320	2310	2227	2156

Key
a Tobacco real price index, constant lira: base year 1980=100.
b Real retail sales index per capita, all store types. base year 1980=100.
c Tobacco products, pieces/grams per person age 15+ years p.a.

Sources *Annuario Statistico Italiano,* Rome, Instituto di statistica
Bolletino mensile statistica May 1988
Main economic indicators historical series 1964-83, and August 1988, OECD.
OECD Policy studies No. 2, *Measuring Health Care 1960-83.* Tables F8 and F11.
Advertising control score: Appendix 4.

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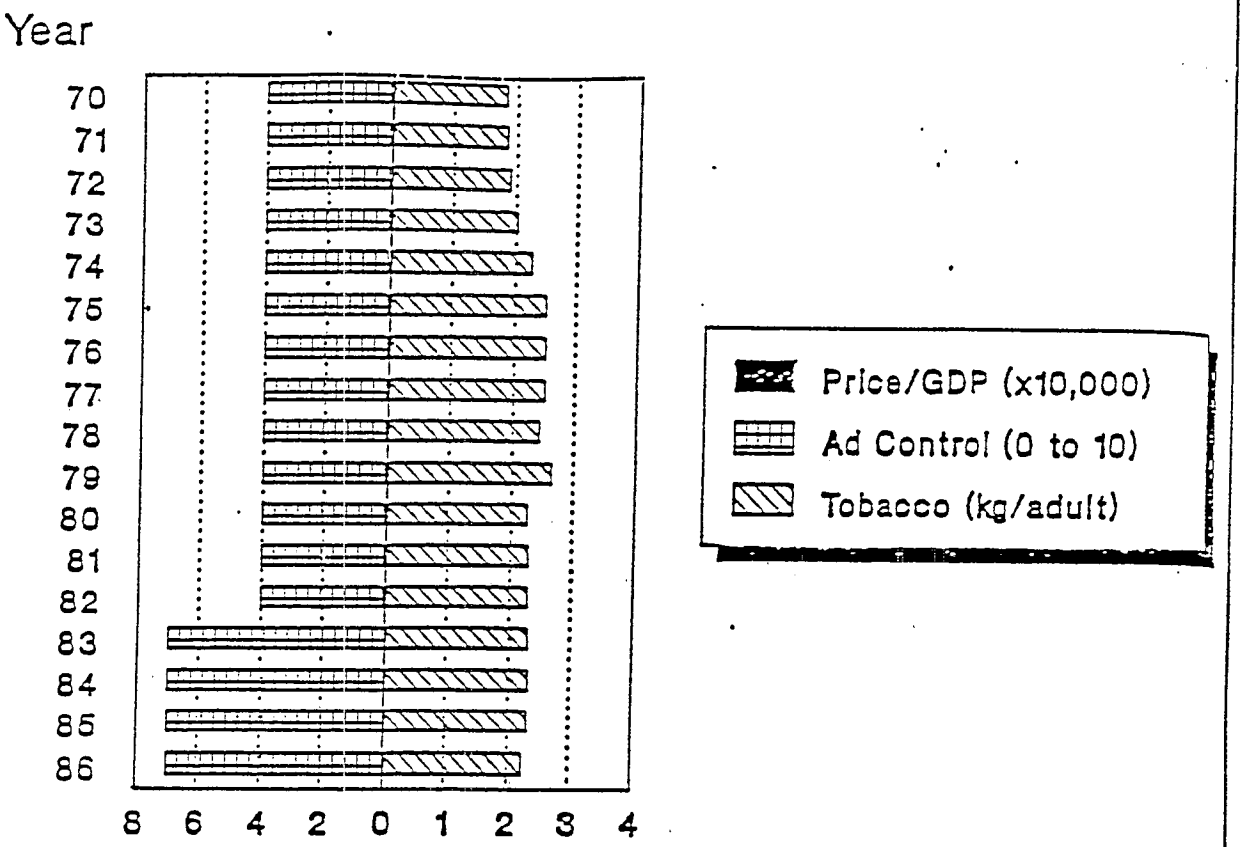
Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Fig 8.3 Italy

Tobacco Consumption Trends



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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

8.6 Tobacco consumption and smoking in Singapore

8.6.1 Government policy

Under the Smoking (Prohibition on Advertisements) Act 1971,[21] the Singapore Government brought in restrictions on the advertising of tobacco products.

The restrictions did not provide for a total ban, as the following were still permitted: advertising on the cinema screen (banned 1981); some point of sale signs; tobacco sponsorships (golf tournaments and beauty contests); indirect advertising (publicising tobacco brandnames through the sale of fashion and other goods).

Singapore has no law against sale to minors, and the packet warning merely says, 'Smoking can damage your health.' Government, however, commenced education against smoking in 1979, increased tobacco tax from 1984, and from 1984 restricted smoking in public places.[22]

8.6.2 Summary of findings

Following the implementations of restrictions on tobacco advertising in Singapore -

- Tobacco consumption peaked in 1974, and tobacco consumption only really began to fall markedly after government starting raising tobacco taxation in 1984. By 1986, tobacco consumption had finally returned to 1970 levels.

- Only 5 percent of 15- to 19-year olds (9 percent males, 0.5 percent females), surveyed eighteen years after the advertising restrictions came into force stated that they smoke.[23]

The highest smoking prevalence is today among men aged 50-59, 50 percent of whom smoke. This means (in marked contrast to New Zealand where young adults have the highest smoking rates), that smoking in Singapore is naturally phasing out as the population ages.

8.6.3 Results and discussion

Singapore is of particular interest in that the two leading manufacturers in Singapore, Rothmans and British American Tobacco, are the same two which dominate the New Zealand market.

A Rothmans' Company secretary speaking of Singapore, was recently reported as saying:

> We believe there will be no growth of the domestic tobacco market because more people have stopped smoking. We have to fight hard even to retain the present market.[24]

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

In 1988, the Canadian tobacco industry publicised Singapore's rising cigarette sales through 1970-87 in full page newspaper advertisements, to urge Canadians to oppose a tobacco 'adban' law by supposedly showing that advertising bans do not work. The figures presented were misleading, omitting the effect of rising population and rising incomes in fuelling demand.

Women smoking

Traditional values, aided by the advertising restrictions since 1970, may have succeeded in protecting Singaporean women for long enough from smoking for a range of other government measures to take effect. In contrast, in Japan, cigarette advertising has recently increased and smoking is now on the increase in young women.

Population

Over much of the period in question, Singapore's adult population increased rapidly (by 55 percent between 1970 and 1986), with adults forming a higher proportion of the population.[25] Taking these population factors into account, it becomes evident that cigarette sales per adult fell in numbers and weight from 1973 to 1986.

Taxation and price

An increase in cigarette sales between 1980 and 1982, associated with increased sales of imported cigarettes,[26] has now been controlled by taxation and the government campaign. However, the price of twenty cigarettes in November 1987 was still only US$0.75.

Per capita income

As in Finland and Norway, rising incomes have obscured the consumption fall associated with the advertising ban. Demand has been fuelled by spectacular increases in present income. Real private consumption expenditure per capita rose 4.5 percent per annum between 1977 and 1987.[27] From published econometric studies, this should have increased consumption by over 2 percent per annum.[28] Instead, from 1977 to 1986, cigarette consumption fell an average 1.3 percent per year.

Affordability

The price of 20 cigarettes as a fraction of income fell steadily from 1970 to 1986, as incomes rose. (Figure 8.6); affordability increased (Figure 8.6).

Figure 8.6 Singapore - Tobacco Consumption Trends

Source: *International financial statistics* (IMF)
UN National accounts. Tobacco Quarterly
PN Lee *Tobacco consumption in various countries*
Tobacco Advisory Council 1975.
Advertising control score Appendix 4
Yearbook of statistics, Singapore.

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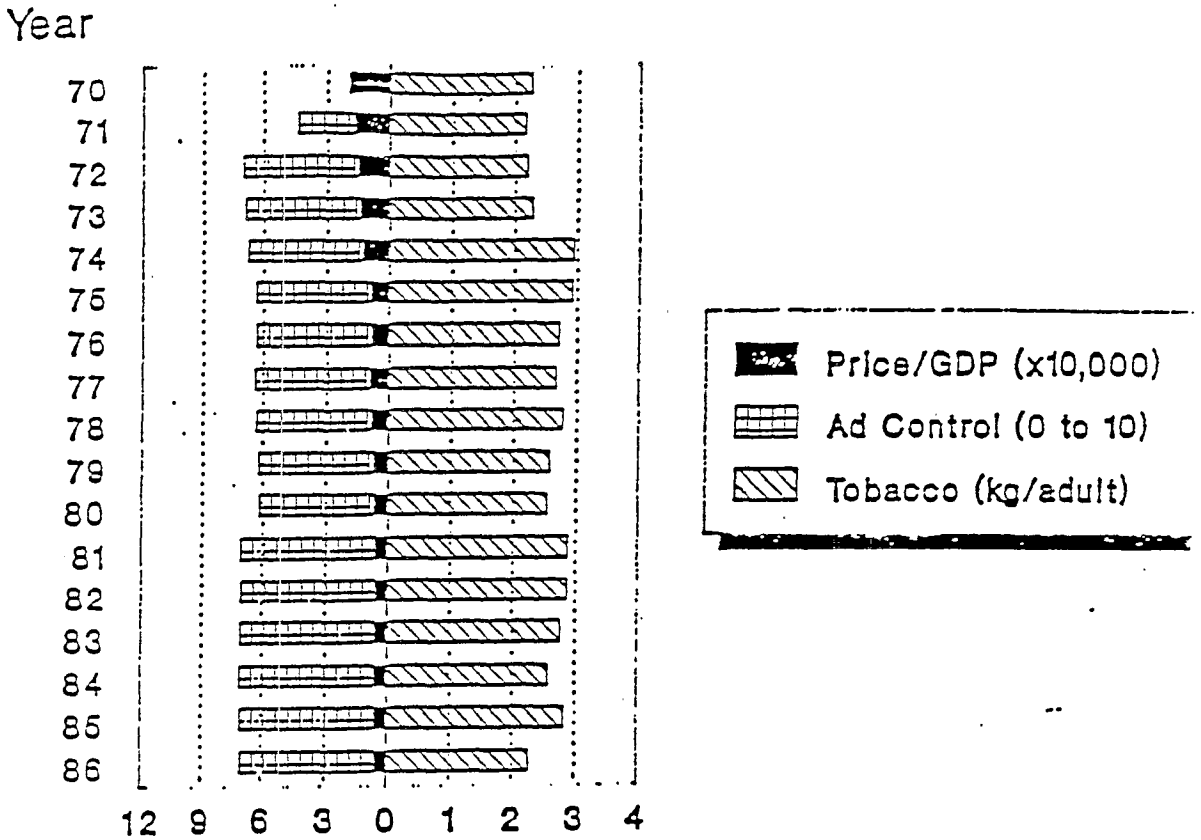
Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Fig 6.6 Singapore
Tobacco Consumption Trends



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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Table 8.6.3 Tobacco Consumption in Singapore

	1970	1975	1980	1985
Advtg. control[a]	0	5.5	5.5	6.5
Real tob. price[b]	117	83	100	109
Real income[c]	68	80	100	116
Tobacco/adult[d]	2265	2919	2537	2821

Notes[a] Advertising control score : see Appendix

[b] Index: base year 1980=100.

[c] Real (constant dollars) private consumpt capita, index base year 1980=100.

[d] All tobacco for smoking, pieces or grams 15+ years p.a.

Sources *Tobacco Quarterly* 1979-88.

Lee, P.N. *Tobacco consumption in various* Advisory Council, 1975.

UN National Accounts, for annual tobacco *International Financial Statistics*.IMF. consumption.

8.7 Tobacco consumption in Eastern European countries

8.7.1 Government policy

In these centrally planned economies, advertising of tobac consumables has never been permitted for politico-ideolog recently in these nine countries, the public have, however, about the dangers of smoking; and warnings on cigarette p been weak. Since 1980, five of these countries have shown consumption per adult.

8.7.2 Summary of findings

As the International Advertising Association has reported, tobacco) consumption per capita (not per adult) in at least e Eastern European countries greatly increased between 197(any further analysis, however, the IAA argued from these advertising makes no difference. No reference was made to about these countries.[30]

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

When consumption was counted in pieces or grams of tobacco per adult, rather than as cigarettes per capita (see 7.4), it was found that, taken as a group, Eastern European countries, had, since 1980:

- Achieved an average decrease of 0.4 percent per year in tobacco consumption from 1980 to 1986 for these nine countries (Table 8.7.3), with a greater rate of decrease seen in the strong partial ban free market countries from 1970 to 1986.

- Achieved this decrease in consumption across the countries in the face of a corresponding average 1 percent growth per annum in personal incomes[31,32] which, other factors being equal, should have raised tobacco consumption by 0.5 percent per year.[33]

8.7.3 Results and discussion

Since 1980, it appears that increasing health knowledge and changing attitudes, accompanied by health warnings on cigarette packets, have been able, in the absence of tobacco advertising, to discourage tobacco consumption in five of the nine countries.

The lack of advertising pressure to smoke in East Europe (apart from some advertising in broadcasts from other countries) is not all-powerful, as suggested by the fact that not all of these countries have reduced tobacco consumption. Tobacco prices, incomes and health education must be considered.

As an example, East Germany is now examined, in particular the various influences behind that country's rising cigarette consumption which began after World War 2 and continued into the 1980s. In East Germany:

- Tobacco taxation is not being used to reduce smoking. For example, the price for cigarettes remained unchanged at 3.20 marks from 1970 to 1986 in East Germany and, during this time, inflation was zero.[34]
- Income per capita has risen at over 4 percent per year since 1970,[35] which would be expected to raise tobacco consumption per adult by 2 percent per year.[36]
- Cigarettes have become more affordable. The price of twenty cigarettes as a percentage of per capita daily income fell from 13 percent in 1975 to 8 percent in 1985.
- There are no strong or varied health warnings. Education of the public on the dangers of smoking is an unknown quantity.

On balance, the net effect is that income growth has stimulated demand for cigarettes in East Germany, more than health education or the lack of tobacco advertising pressures have been able to lower demand.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Table 8.7 Tobacco consumption in Eastern European countries, 1980-86, grams per adult

Year	1980	1982	1984	1985	1986	% p.a. change 1980-86
Albania[c]	1254	1249	1187	1159	1183	- 0.9 down
Bulgaria[c]	2330	1854	4808	2661	2282	- 0.3 down
Czechoslovakia	2612[a]	2555	2550	2401	2374	- 1.8 down
E.Germany(FDG)	2403	2252	2506	2396	2408	0.0 =
Hungary	3420	3166	3291	3263	3246	- 0.8 down
Poland	3529	3374	3203	3341	3558	+ 0.1 =
Romania[c,p]	2028	2194	2121	2107	2071	+ 0.4 up
Soviet Union[c]	2106	2082	2161	2145	2149	+ 0.3 up
Yugoslavia	3266	2912	3045	3141	3088	- 0.9 down
Average of the group						- 0.4 down

Key
- a 1981 data.
- c Manufactured cigarettes only
- p Production only
- = Less than 1 percent chang

Note: Data includes domestic production, but not trade, in cigars and other manufactured tobacco, unless otherwise noted.

Sources: *Demographic yearbook*, United Nations, 1980-86
World statisticsin brief, 11th ed. United Nations 1987.
Tobacco Quarterly, 1979-88.

Comparison with Western European countries at a comparable early stage of public awareness about the risks of smoking (for example Spain and Greece, where advertising has been permitted in all media, and consumption has continued to rise) suggests that the average fall in tobacco consumption in the Eastern Europe bloc of 0.4 percent per year would not have been achieved in the face of unrestricted tobacco advertising. This is a worthwhile result.

The experience of Eastern European countries since 1980 is not an argument against the elimination of tobacco advertising outside the East European bloc. Their experience does argue for the importance of educating the public in all countries, on the health consequences of using tobacco, together with firm advertising policies.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

8.8 Tobacco and cigarette consumption and smoking in New Zealand

8.8.1 Government policy

Education of the young about smoking was the emphasis forty years ago, and still is today.

Partial tobacco advertising bans have been in place for a quarter of a century, since the first voluntary agreement ended billboard and cinema advertising and introduced health warnings on cigarette packets.

Taxation helped raised tobacco prices about 40 percent in 1958 and over 50 percent in 1986.

Table 8.8a Tobacco control versus promotion measures applied in New Zealand

Promoting tobacco budget $7-11m	Duration in years	Promoting non-smoking budget $0.4m	Duration in years
Multi-media new brand promotions and advertising	28	Low key education on the dangers of smoking	40
Increased tobacco sponsorship advertising	15	Warnings on tobacco packets	25
Increased cigarette advertising	10	Partial cigarette advertising controls	25
Low tar brand promotion	13	An effective tobacco price policy (enough to raise the real price) 1984-86, and 1988	4

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Table 8.8b Tobacco consumption, prices and promotion in New Zealand since 1975-87

Year	1975	77	79	81	83	85	86	87	88
Cigs./day/15+[a]	7.9	7.8	7.4	7.3	7.0	6.3	5.8	5.8	5.8
Tobacco g/15+[b]	3219	3143	2960	2905	2769	2493	2304	2328	2328
Income /capita[c]	96	98	98	104	97	102	97	89	106
Minutes to earn 20 cigs[d]	11	11	9	11	11	12	11	16	na
Cig. advertising print,1988$m[e]	4.0	6.6	4.1	3.7	3.9	3.3	2.6	2.9	4.7
Tobacco sponsored hours on TV[f]	19	18	48	54	111	178	182	162	na

a *Monthly abstract of statistics*, Department of Statistics, manufactured cigarettes released for sale data and mean population age 15 and over.

b Total tobacco per person 15+ years released for sale annually: *Monthly abstract of statistics* includes all tobacco for smoking, but cigars only included from 1988.

c Real retail sales (all goods all stores) per capita index: base year 1980=100.

d *Prices, wages and income*. Department of Statistics.

e Press Research Bureau rate card estimates in millions of 1988 dollars.

f Department of Health, from the *NZ Listener* programme lists.

8.8.2 Summary of findings

- In New Zealand, tobacco consumption per adult peaked in 1963 and has fallen over 30 percent since.
- Tobacco consumption per adult in 1986 was, however, still higher than in the UK, Norway, Finland, Sweden, Italy and France (see Appendix 3, Table A3.2).

8.8.3 Results and discussion

Overall, tobacco consumption among New Zealanders and smoking uptake in young people remain high.

Affordability

In the early 1970s, the price of twenty cigarettes as a fraction of daily income was decreasing, that is cigarettes were more affordable; cigarette consumption rose each year. Since 1984, this trend has reversed, and tobacco is now less affordable (Figure 8.8).

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Figure 8.8 New Zealand - Tobacco Consumption Trends

Source : Price data : Department of Health
International financial statistics (IMF)
Monthly abstract of Statistics.
Advertising score: Appendix 4.

Tobacco promotion

The restrictions on tobacco promotion have been voluntary and so the total tobacco advertising budget of the industry has not been curtailed.

As Table 8.8b shows, tobacco promotion by the industry is well funded, and government health education funds cannot match such expenditure (Table 5.1).

After television and radio were closed off for tobacco product advertising from 1963, the tobacco industry directed its advertising expenditure into printed media, and early on developed sponsorship of sport. Government pressure restricted advertising content in 1979. Televised sponsorship of sport which costs relatively less than other media, has helped maintain brand awareness and incidentally has brought back paid advertising of cigarette brandnames on television.

Cigarette print advertising fell 50 percent from 1977 to 1987, but televised sponsorship hours increased about *tenfold* in this period. Cigarette consumption fell 26 percent in these ten years, but the decrease has been more rapid, 5.7 percent per year, since 1984 (Table 8.8b).

Advertising controls along with price increases can, on annual data, explain most of the variance in year-to-year tobacco sales in New Zealand (see 6.2 under New Zealand). If tobacco advertising were eliminated in New Zealand, then assuming tobacco prices and incomes remain stable, a further permanent fall, in national tobacco consumption would seem likely. This is further discussed in Chapter 12.

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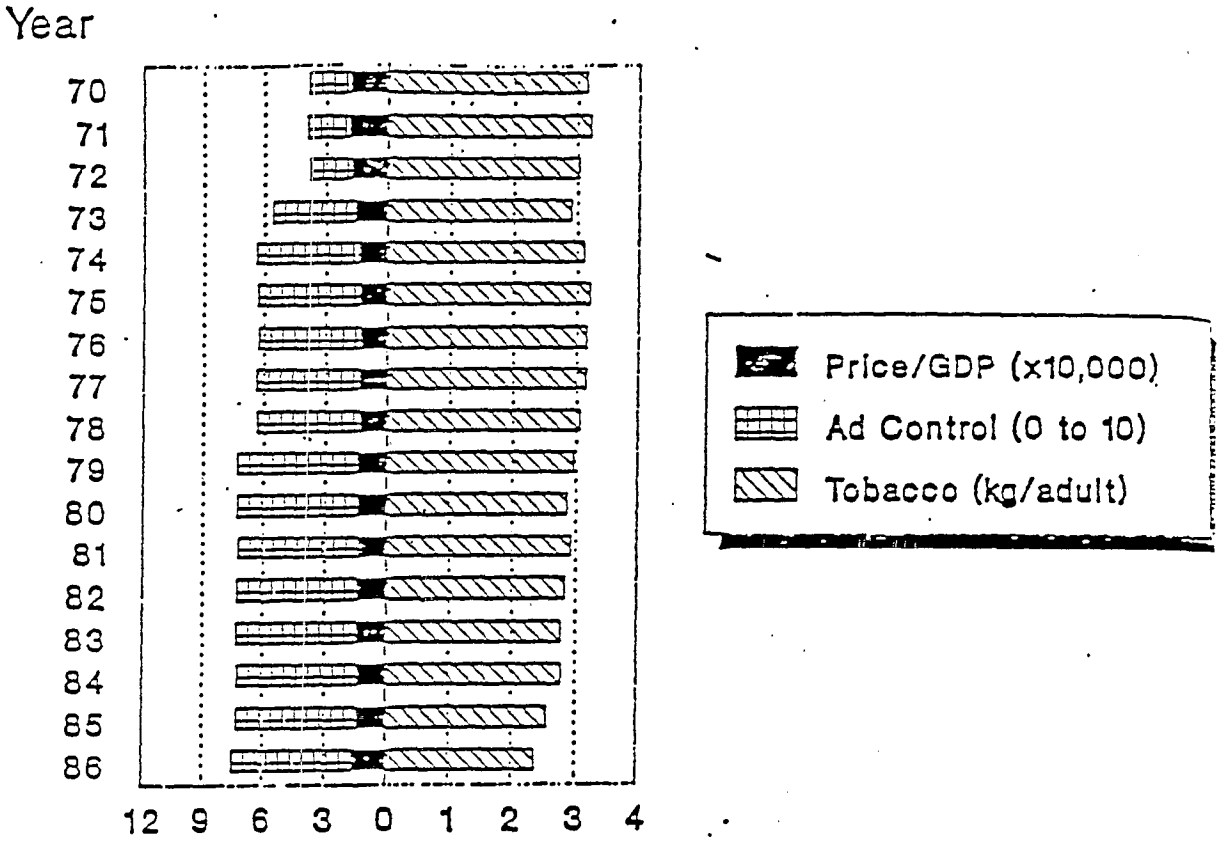
Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Fig 8.8 New Zealand
Tobacco Consumption Trends



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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

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20 Italian Embassy Wellington. pers. comm.
21 Smoking (Prohibition on Advertisements) Act 1971, *Statutes of the Republic of Singapore*, revised edition 1985, ch.309.
22 Permanent Secretary (Health) Singapore letter of 20 October 1987 to N.Z. Department of Health
23 Singapore Government survey on smoking, 1979.
24 *Wall Street Journal (Europe)* 24.9.87
25 *Yearbooks of Statistics*, Ministry of Communication, Singapore.
26 *Tobacco Quarterly* 1979-1988 production and trade data
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29 *Tobacco Advertising Bans in 16 countries* . Boddewyn JJ ed.- New York; International Advertising Association 1986.
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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

PART THREE: POLICY IMPLICATIONS

9. SMOKING AND TOBACCO ADVERTISING - THE NECESSITY FOR COMPREHENSIVE HEALTH POLICIES

Summary

Comprehensive policies to reduce tobacco consumption are much more effective than any single measure. Comprehensive anti-tobacco policies are recommended by the World Health Organisation and, in New Zealand, by a succession of expert committees.

The three essential features for an effective government policy to reduce the health consequences of tobacco use are:

- Programmes to educate the public about the dangers of tobacco use.
- The raising of tobacco prices.
- A total ban on tobacco promotion.

These measures are the pre-conditions for a smoke-free society, where

- adults are free to choose to smoke or not, without persuasion to smoke;
- nonsmokers have smokefree surroundings;
- the younger generation can grow up free of tobacco addiction - a smokefree generation.[7]

New Zealand has tried various policies over the past forty years to discourage smoking, but only now are the most effective policies being implemented: tobacco prices are being raised, the elimination of tobacco advertising is being considered, and funds for education and publicity are being increased somewhat.

9.1 Comprehensive approaches work best

Discouraging smoking is now a goal of the New Zealand Government. The Minister of Finance, in his July 1988 Budget speech, referred to the fact that the discouragement of smoking is a government aim. This aim is also indicated in a number of recent policy moves (see Table 9.1).

New Zealand research (see Section 6), expert opinion from overseas,[1] and experience in many countries in recent years (see Sections 7 and 8) show that the most effective policy package available to governments for promoting non-smoking includes the following:

- Raising the price of tobacco products.
- Educating the public on the dangers of smoking.
- Eliminating tobacco advertising and promotion.

This section documents the force of opinion that exists to persuade governments to adopt such policies.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

9.2 Expert bodies - views and policy recommendations

- World Health Organisation's Expert Committee on Smoking Control, 1979: (recommendation addressed to all countries).[2]

  The Committee recommends that non-smoking should be regarded as the normal social behaviour and that all action which can promote the development of this attitude be taken. There should be a total prohibition on all forms of tobacco

  > Firm action to control smoking has been opposed by the tobacco industry, primarily on the grounds that such action is an unnecessary constraint on freedom and that evidence of the efficacy of such action is insufficient. Neither of these arguments is acceptable... The case, the Committee said, for the introduction of these measures, is overwhelming, and would make no infringement of individual liberty beyond what is acceptable in an organised society... there is good evidence from around the world to indicate likely effectiveness... at worst (such measures) do no harm... any Government that waits for 'proof' of effectiveness bears the responsibility of knowing that its inactivity has helped to promote premature death and disease. Allowing tobacco promotion to continue is permitting an experiment, which in the view of the Committee, has already had the most serious health consequences and will maintain if not increase those ill effects. [2]

- The Director General of the World Health Organisation: Dr Halfdan Mahler

  > Tobacco smoking and the diseases it causes have reached pandemic proportions in the developed countries. As tobacco uses is a multifaceted problem, multiple approaches are needed to tackle it. Among these are: legislation to restrict smoking and limit the promotional power of the tobacco industry... Addiction to smoking is spreading like a pandemic throughout the world.[3]

- The World Health Assembly

  This organisation, of which New Zealand is a member, at its 39th Assembly in May 1986, urged member states to implement smoking control strategies.[4]

- The Advisory Committee on Smoking and Health (New Zealand)

  The Committee's 1985 Comprehensive Policy for the Promotion of Non-smoking adopted a goal of 80 percent of adults to be non-smokers by 1990 (in 1987, 72 percent were non-smokers). On tobacco advertising and promotion, the Committee recommended restriction and, eventually, elimination.[5]

- The Director of Public Health and the Department of Health

  The Director of Public Health, Dr Maxwell Collins, who was responsible for all negotiations on tobacco advertising with the industry, on behalf of successive Ministers of Health from 1973 to 1985, notified the Health and Welfare Committee of Parliament in 1983 that the Department of Health supported in principle a total ban of cigarette advertising.[6]

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- The Advisory Committee on Prevention of Cardiovascular Disease (New Zealand)

In its 1986 report to the Minister of Health, with reference to policies to control smoking, this Committee endorsed the goals of the Advisory Committee on Smoking and Health.[7]

- The Royal Colleges and Faculties of Medicine

In 1985, the Royal Colleges and Faculties of Medicine, submitted this statement to the Minister of Health:

> We, the specialist medical Colleges and Faculties in New Zealand, are writing to request that you take vigorous measures, including legislation if necessary, to prevent tobacco manufacturers from promoting their products in persuasive ways which undermine the impact of health education on the behaviour of children and adults.
>
> Our Colleges applaud the efforts the Department of Health has taken in publicising the grave risks which smokers are taking. However, these efforts are unlikely to be as effective as they could be whilst there is a continuous promotional campaign by the industry which associates smoking with a glamorous, sophisticated and adult lifestyle.
>
> By its nature, the voluntary agreement signed from time to time by the Minister of Health and the cigarette manufacturers cannot be as effective as we would wish. Indeed it seems unreasonable to expect the industry to voluntarily accept any effective agreement aimed as reducing sales and, therefore, usage. The only effective option is a complete ban on advertising, including the extremely cheap advertising which the industry obtains through sponsorship of sport and cultural activities.[8]

- The Toxic Substances Board 1986

The Toxic Substances Board in a report to the Minister of Health in July 1986, recommended stronger warnings on tobacco packets, no sale of tobacco to under-16-year-olds, and the elimination of tobacco promotion.[9]

9.2.1 The long-term goal

The World Health Organisation and its member countries have this overall objective: Health for all by the year 2000.

A smoke-free society by the year 2000, first suggested by Everett Koop, the United States Surgeon General until 1988, is an essential and elementary goal, for it means a society:

- with smokefree environments;
- where adults are free to choose to smoke or not, without persuasion to smoke;
- Where the younger generation can grow up free of tobacco addiction - a smokefree generation.[7]

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This goal does not mean stopping the sale of tobacco to adults. With 0.732 million cigarette smokers,[10] of whom between 356,000 to 568,000 are addicted,[11] no New Zealand government could consider stopping the supply of tobacco. Apart from the risk of addiction driven-crime, blackmarkets and social mayhem, such a policy would be neither compassionate nor effective.

9.3 Aims and policies - the New Zealand situation

The Department of Health commenced health education and public information against smoking in 1948, and the Cancer Society and National Health Foundation have also been involved for several decades.

The goal of the Department of Health is that the year 2000 will see only 15 percent of adults as smokers, and tobacco consumption reduced to 1000 grams per adult per year (whether smokers or not). This goal should be feasible, as by 1987 it had already been achieved among those with tertiary education.[12] The goal for 1991 is that no more than 25 percent of adults will be smokers (4 percentage points below the 1988 level) and that tobacco consumption will be reduced to 1,800 grams (23 percent below the 1988 level).

As already mentioned, the Government itself has stated its intention to discourage smoking.[13]

A wide range of policies have been used over the years in New Zealand, and these are documented in Table 9.1. The methods which most powerfully and certainly lower tobacco consumption are only now beginning to be tried. Policies which have not yet been adopted are listed here:

- Elimination of tobacco advertising.
- Repeated tobacco price rises.[14]
- Repeated publicity and educational campaigns.
- Legislation for the creation of smoke-free indoor environments, including workplaces.[15]
- Measures to stop gifting of free samples of tobacco.
- Measures to further lower tar yields in cigarettes.
- Intensified cessation programmes for smokers trying to quit.

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Table 9.1 Policies applied or available for promoting non-smoking, New Zealand 1963-1980

Policy	Year first Implemented
No cigarette advertising on television or radio	1963
No cigarette advertising on cinema or billboard	1973
Warnings on cigarette packets, weak wording	1973
Restrictions on smoking in aircraft	1974
Census question on smoking	1976
Government Advisory Committee on Smoking and Health	1977
Retractions on advertising content	1979
TV campaign to help teenagers stay nonsmokers	1979
Smoking intervention teacher kits issued to schools	1982
First published estimate of 3600 deaths due to smoking	1983
National smokefree week to help smokers quit	1986
Department of Health offices become smokefree	1987
Regional estimates of smoking deaths *The Big Kill*[16]	1988
Regulation to stop sale to under 16s	1988
Reserve Bank credit for tobacco growers stopped	1988
Planned tobacco tax prices spread through the year	1988
Restrictions on indoor smoking voted in 3 cities	1988
Creating Smokefree Indoor Environments[15] published	1988
Smoking on aircraft banned by airlines	1988

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

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2 *Controlling the smoking epidemic: report of the WHO expert committee on smoking control.* Technical Report Series No. 636, World Health Organisation, 1979, p.72.

3 Executive Board of the World Health Organisation Annex 3. *Tobacco or health: report by the Director General*, 15 November 1985, p.1.9

4 Resolution WHA 39.14.

5 *Comprehensive policy for the promotion of nonsmoking*: Advisory Committee on Smoking and Health, May 1985, Wellington, Department of Health.

6 Response to Petition No. 1983/85, Dr M. Collins, Director of Public Health, to Chairman, Health and Welfare Committee, Parliament.

7 *Report of the advisory committee on prevention of cardiovascular disease.* Wellington, Department of Health, 1986.

8 Letter from the Royal Specialist Medical Colleges and Faculties to the Minister of Health (New Zealand), 1985.

9 *Recommended controls on yobacco for smoking under the Toxic Substances Act 1979, Report to the Minister of Health from the Toxic Substances Board, July 1986.* Wellington, Department of Health, 1986.

10 OTR Spectrum continuous doorstep surveys of over 10,000 persons per year, in the year to September 1988, regular smokers of any cigarette.

11 In the Cancer Society NRB poll of 1987, 47 percent of cigarette smokers said they would find it very difficult to give up smoking for one week, and an additional 28 percent said it would be fairly difficult to give up.

12 OTR Spectrum doorstep surveys of over 10,000 for the year ending July 1987.

13 Budget speech of the Minister of Finance, 28 July 1988.

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16 *The big kill: the human cost of smoking in New Zealand.* Wellington, Department of Health, 1988.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

10 PUBLIC OPINION IN NEW ZEALAND ON TOBACCO ADVERTISING AND SPONSORSHIP

10.1 Polls on tobacco advertising

Public opinion in New Zealand favours the elimination of tobacco advertising. It is not just non-smokers who favour such a ban; a majority of smokers do also. A 1987 poll commissioned by the Cancer Society and conducted by the National Research Bureau on a national sample of 2000 persons, found that 70 percent of never smokers, 66 percent of ex-smokers, 54 percent of smokers and 65 percent of all surveyed supported a ban on cigarette advertising.[1]

Another poll commissioned by the Cancer Society and conducted by the National Research Bureau (NRB) was conducted on a national sample of 2,200 persons in 1984.[2] One was also carried out by AGB in 1988 on a sample of 1,507 for the Department of Health.[3] These, along with the 1987 NRB poll, showed that a clear majority of public opinion supports the elimination of tobacco advertising (see Table 10.1).

Table 10.1 National public opinion polls on a cigarette advertising ban

Question	Response	1984	1987	1988
		percent		
Would you yourself support or oppose a ban on cigarette advertising?[a]				
	Yes	53	65	66
	No	26	23	32
	No opinion	21	12	1

[a] The 1988 poll simply asked: *Do you agree or disagree that tobacco advertising be banned?*

10.2 Polls on tobacco promotion through sponsorship

When it comes to the question of whether or not tobacco sponsorship should be eliminated, the community opinion remains split (see Table 10.2). Opposition to tobacco industry sponsorships is, however, increasing.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Table 10.2 Polls on tobacco sponsorship : 23 urban areas in New Zealand

Question	Response	1978	1982	1988
		percent		
Do you favour limiting the sponsorship activities of the tobacco industry?	Yes	17	22	28

Source : MRL Research Group, polls of 1000 adults, 500 male and 500 female heads of households, in 23 main urban areas.

The 1984 NRB poll asked those surveyed to respond to this statement: 'Sponsorship of sport and cultural events by cigarette companies is welcome, but only if no cigarette brand names are shown or mentioned.' Thirty-nine percent said yes; 35 percent no, and 26 percent were not sure.

The 1988 AGB poll (in the context of many questions about health) asked its respondents to react to the statement, 'Tobacco sponsorship should be banned.' Forty-seven percent said yes; 52 percent no; and 2 percent were not sure.

In 1988, of those opposing tobacco sponsorship, the main reasons cited were 'bad effects on health' (46 percent), 'does not go with sport or promote a healthy image' (27 percent), 'bad effect on the young' (16 percent) and 'should not be using sponsorship for advertising' (15 percent).[4]

10.3 Petition to Parliament

A petition dated 1 July 1987, from Trevor Reeves and Judith Wolfe,(of the Tobacco Advisory Council) and 4,212 others to the New Zealand Parliament, prayed that, 'Since tobacco is a toxic substance and unfit for human consumption, an advertising and promotion ban be placed on all tobacco products.'
This petition was heard by the Social Services Select Committee, which reported to Parliament on 3 December 1987. The Committee recommended that the petition be referred to the Government for favourable consideration.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

NOTES AND REFERENCES

1 Cancer Society of New Zealand National Research Bureau poll, November 1987, national sample, poll of 2000 persons age 16 years and over.

2 Cancer Society of New Zealand National Research Bureau poll, national sample, 2,200 persons.

3 NBR poll carried out for Department of Health, national sample, 1,507 adults age 15 and over.

4 MRL Research Group survey of 1000 persons in 23 main urban areas, May 1988.

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11. TOBACCO PROMOTION - PRINCIPLES AND RECOMMENDED POLICIES

11.1 Principles

Part One of this report highlighted two important concerns:

i) Smoking causes a large toll in New Zealand each year in terms o disease and disability (Chapter 3).[1]

ii) Young people are continuing to take up smoking (Section 4.1).

As shown in Chapters 7 and 8 of this report, in those countries which h eliminated tobacco promotion, particularly when in association with ot nonsmoking initiatives and not counteracted by such effects as rising ir rates of tobacco use have tended to decline amongst adults and teenage

The link between the elimination of tobacco promotion and a decline i consumption rates has yet to be proven to be causal in the same right w tobacco smoking has been proven to cause many diseases.[2] The Unite Surgeon General's report concludes that '....it is more likely than not advertising and promotional activities do stimulate cigarette cons and certainly a strong association exists.

The Toxic Substances Board considers, therefore, that the policies of Government or health or other concerned agency should be guided by following principles:

1) The promotion of nonsmoking should be a major priority of any service.

It is feasible to prevent much tobacco-caused disease in this way. W must continue to be devoted to treating smokers,[4] tobacco-caused he disease often shows itself only when far advanced,[5] and causes needl Cure is difficult, uncertain, always expensive and often impossible.[6]

2) Everything possible should be done to ensure that young people smoking or continue smoking.

This should involve a combination of approaches, such as raising ta tobacco products and ensuring smoke-free schools, well-funded hea and the elimination of any persuasion to begin or continue smoking.

3) A toxic substance which is known to cause over 4000 premature year in New Zealand should not be advertised as fit for human let alone associated with any healthy, vigorous, glamorous or w activity.

For this reason alone, the advertising and sponsorship of tobacco sh eliminated.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

4) No government agency should feel it must prove that tobacco promotion causes young people to begin smoking, before it will consider steps to eliminate such promotion.7

Action is justified because smoking causes ill-health on a large scale and because young people are continuing to take up smoking.

5) Such a policy can be recommended even if there is no certainty of any immediate decline in teenage tobacco use.

A ban on tobacco promotion would demonstrate that government is seriously committed to releasing young people from tobacco. Also it would ensure that the media would be completely objective in publishing health information on the negative consequences of tobacco use.

A policy aimed at eliminating tobacco promotion would be in accordance with that recommended by international health agencies.

11.2 Recommendations

The Toxic Substances Board recommends that:

1) Tobacco advertising and sponsorship in all their forms be totally eliminated throughout New Zealand from December 1990.

The concept of 'tobacco advertising and sponsorship' applies to tobacco products and smoking accessories, and includes tobacco industry sponsorship, tobacco corporate advertising, free or subsidised distribution of tobacco products, coupons, contests and any other or new form of tobacco advertising and indirect advertising of any other goods, using tobacco product brandnames or logos.

2) Only two exceptions should be permitted:

- o Specific factual tobacco product information, including price, may be displayed in specified format at points-of-sale.
- o Tobacco advertising in foreign magazines and newspapers (this exception not to include any New Zealand edition).

3) Government should ask the Hillary Commission

- o To consider the impact of the elimination of tobacco sponsorship on those sports, cultural and other groups who are presently dependent to some extent on it.
- o To play a role in any action which may be decided.

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11.3 Comments on these recommendations

1) The above recommendations are similar to those incorporated in the Canadian Tobacco Products Control Act 1988 (a copy of the Act is given in Appendix 2).

> The Act's purpose is to provide a legislative response to a national public health problem of substantial and pressing concern and, in particular,... to protect young persons and others, to the extent that is reasonable in a free and democratic society, from inducements to use tobacco products and consequent dependence on them...[8]

The Tobacco Products Control Act came into force on 1 January 1989. It extends to the sponsorship of cultural and sporting events. It also includes

- Requirements for strong health warnings on tobacco packets,
- Provision for leaflets which inform smokers on health effects to be included in tobacco packets.

The Canadian legislation was very much opposed by the Canadian tobacco manufacturers and some associated business groups. But it received massive support from health agencies and was also favoured by the general public (see 8.8, Table 8.8.1). The Bill received all-party support at the political level.

2) The date of December 1990 is suggested for the start of a ban in New Zealand because, from 16 December 1990, the current Agreement between the Minister of Health and the tobacco manufacturers relating to tobacco promotion expires. The intervening time will give the industry and bodies receiving sponsorship time to adjust and plan for the change.

3) The Toxic Substances Board stresses strongly that tobacco sponsorship must be eliminated at the same time as tobacco product advertising. Not to do so would be pointless, as the effect would simply be to free-up funds for advertising by means of tobacco sponsorship.

4) The Board recognises that some sports and cultural groups may not believe that they can replace their tobacco-funded sponsorship.

- Many sports, however, have consciously adopted a policy of not accepting such sponsorship and still flourish. The Cricket Council in the United Kingdom, for example, voluntarily switched from a tobacco sponsor to an insurance company.
- Although in some jurisdictions, for example those of Victoria and South Australia, provision is made for support of sports from tobacco tax, the Board does not consider that government has a duty to provide such compensatory funds.

5) The definition of advertising and sponsorship so as to include free samples and other such aspects follows the Canadian Act.

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6) The two exceptions would be permitted because:

- It is considered that factual information should be available to assist purchasers to make comparisons between brands on price and on tar and nicotine yields.

- No practical way exists to disallow tobacco advertising in foreign magazines and newspapers. Foreign publications make up more than half of the top thirty selling magazines in New Zealand. Most come from Australia. However, New Zealand editions in both editorial and advertising content would not be excepted. This problem will diminish with time, as complementary legislation is brought in or takes effect overseas.

The same problem has been faced in Canada, with magazines imported from the United States. The positive effects of a ban will occur despite some magazine advertisements coming in from overseas.

11.4 Other possible policy options

The Board considered possible alternatives to the elimination of tobacco promotion. These were:

1) Health advertising to counter the effects of tobacco advertising

Health advertising to counter the effects of tobacco advertising would be extremely expensive, perhaps prohibitively so. Funding at a level that might be partially effective cannot be relied on, as the health sector is always under pressure to reassess its funding priorities.

2) Disallowance of tobacco advertising expenditure as a tax-deductible item

Disallowing tax deductibility for tobacco advertising would, at present company tax rates, achieve little benefit.

3) Further controls on advertising content

Further control of content would give diminishing returns. Focusing on romance, sex, glamour, sport and success in tobacco advertisements have not been allowed since the 1979 Agreement. In 1988, the human form (except hand and forearm) was excluded in New Zealand tobacco advertisements. The result is that today, when compared with Australian ones up 1988 at least, New Zealand cigarette advertisements in magazines appear restrained, consisting mostly of brandname logo, basic product information, warning and advertising slogans. Content is not the main problem.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

4) Elimination of advertising in some media, not in others - a partial advertising ban

This method has been applied in New Zealand since 1963. An advertising ban in all but one medium (partial ban), means that tobacco advertising dollars, more than 10 million of them, can be transferred to the remaining medium. Alternatively, new uncontrolled media could be used. The United States tobacco industry, for example, spent $454 million dollars on direct mailing in 1987.[9] This technique has yet to be used to any great extent in New Zealand.

5) Using the tobacco advertisement to convey the health message

Fifteen percent of the advertisement is already reserved for the health warning. It is doubtful if a greater percentage could be used.. Even if advertising were banned, the warnings will continue to be carried on approximately 250 million tobacco packets per year.

6) Higher taxation of tobacco products

Taxation alone is insufficient. There will come a time - although New Zealand is still far from it - when price cannot be raised higher except to adjust for inflation.

11.5 Conclusions

From the evidence presented in this report, and for the reasons given in this section, the Board's conclusions are that:.

- o tobacco promotion should be eliminated on grounds of principle;
- o a total ban is likely to lower tobacco consumption significantly;
- o a partial ban would have little effect on consumption.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

NOTES AND REFERENCES

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2 *Reducing the health consequences of smoking: 25 years of progress. A report of the Surgeon General*, 1989, U.S. Department of Health and Human Services p. 161.

3 Ibid, p. 513.

4 Gray, A.J. et al. as cited above, calculated the hospital costs alone of treating smoking-related disease at $100 million per annum in 1985 dollars.

5 *Cancer data new registrations and deaths 1983*, National Health Statistics Centre Table 11. In less than one quarter of lung cancer cases registered in 1982-83 was the cancer localised to the lung itself when diagnosed.

6 *Cancer survival in New Zealand special report no. 69*. National Health Statistics Centre relating to patients diagnosed in 1968-70 gave a 5 year survival (relative to age) of only 13 percent for men with lung cancer and 10 percent for women with lung cancer.

7 It can be noted here that the tobacco industry still do not accept the Surgeon General's conclusions since 1964 that tobacco causes serious and fatal disease. In fact they do not concede that smoking causes any serious ill-health of any kind in any smoker or passive smoker. Given the overwhelming evidence for the Surgeon General's conclusions, it is difficult to envisage what 'proof' would satisfy the tobacco industry, or to envisage under what conditions commercial realities would ever permit such an change of their position.

8 *Canadian Tobacco Products Control Act 1988*, section (3).

9 Dagnoli, J. Tobacco giants dig deeper into promotion. *Advertising Age* May 23, 1988.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

12. ESTIMATED EFFECTS OF THE ELIMINATION OF TOBACCO PROMOTION

12.1 Negative aspects

1) Adverse effect on employment

Tobacco manufacturers told Board members that a total of 150 to 200 jobs would be lost. These job losses would affect

- o sales staff of the manufacturers who erect shop displays and signs and visit shops selling tobacco;
- o print control staff of the manufacturers,
- o several small businesses who make and print tobacco advertising signs,
- o the advertising agency of each manufacturer.

2) Adverse effect on industry profits

Tobacco manufacturers would save about $11 million per annum - representing the amount they would have spent on tobacco promotion. According to the manufacturers, tobacco sales will not fall, which means that sales revenue would not be affected.

The $11 million saved in the first year is equivalent to one-off payments of $73,000 per person made redundant by an adban. The savings would continue each year, however, so after providing for one-off redundancy costs in the first year, future profitability would improve.

By opposing a tobacco advertising ban, the manufacturers are rejecting the chance to save $11 million between them. Is the freedom to compete with each other in the media really worth forgoing savings of $11 million? The answer must be that:

- o Advertising presently brings in more profit for each manufacturer than each spends on advertising, or
- o The manufacturers know or fear that a ban on advertising will cause tobacco sales to fall, or
- o Both of these statements are true.

If, in fact, as indicated in this report, an advertising ban does have an effect on tobacco consumption, there will be an impact on industry profits. The impact will be gradual, however, and the industry has considerable time in which to adjust.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

3) Alteration of market dynamics

As consumption continues to fall (against the predictions of tobacco manufacturers), current trends for retailers to stock fewer brands or to demand higher margins will be accentuated. Brand competition will remain, but marketing methods other than advertising will assume increased importance.

Price discounting in supermarkets might increase somewhat, but damaging price wars have not been seen in other countries which havbanned tobacco advertising. Although manufacturers deny that an advertising ban will cause consumption to fall, when faced with falling sales, they may raise prices to recoup revenue, even if in the long run sales fall still further.

Inter-company rivalry, brand for brand, will remain. New brands will be launched, but manufacturers will have to rely on trade magazines and contact with retailers. More popular brands may increase their market shares.

A third major manufacturer may find it much more difficult to establish its brands and to enter the New Zealand market.

4) Slightly reduced price awareness and price responsiveness amongst smokers

Awareness of the price of tobacco products is predicted to drop slightly following an advertising ban. At present, in New Zealand, a price rise of 10 percent produces a 1.4 percent fall in consumption for the year following. After a ban, a price rise of 10 percent would result in a 1.3 percent drop in consumption.[1]

5) Possible loss of awareness of less dangerous types of cigarette

The manufacturers believe they should have the right to inform the public of a number of product characteristics, so that, for example, low tar and other less dangerous types of cigarette can be brought to public attention. (The tobacco viewpoint was examined in detail in 7.5.3.)

A study of advertisement slogans shows how little tobacco advertisements inform consumers. Common slogans in use today such as 'Styled For Today', and 'What a Sterling Idea', are not informative. Cigarette advertisements are careful to omit any detailed product information about nitrosamines and other carcinogens.

If the Department of Health considers the public needs to be warned or informed about cigarettes, it has adequate powers for dealing with the situation and can:

- o require the manufacturer to insert an educational leaflet in the cigarette packet, as in Canada.
- o publicise the matter itself at no cost to the manufacturer,
- o regulate under the Toxic Substances Act 1979 to eliminate high tar levels in cigarettes, as has been done in Finland.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

6) *Need for alternative funding* to replace tobacco sponsorship of sport, culture and the arts

Currently, tobacco manufacturers spend about $1 million per year in New Zealand sponsoring various events in sports, culture and the arts. In the past, recipient groups have opposed any move to divest them of tobacco sponsorship. The Board's Tobacco Subcommittee had a lengthy discussion with Mr James Haggerty of Global Sports & Promotions Ltd; and with Mr Peter Hoobin, Executive Director of the Mercury Theatre. From these disucssions it became clear that the nature and effects of sponsorship for the sponsored bodies vary quite widely. As such, care will be needed to minimise the short-term bad effects of a tobacco sponsorship ban on sporting and cultural bodies.

Policy alternatives for replacement of tobacco sponsorship include:

- Providing no government monies but allowing sports groups sufficient time to arrange non-tobacco sponsorships.
- Bridging grants for one to three years to assist tobacco-sponsored recipients to find alternative funding, perhaps out of lottery profits.
- Enhancing sports funding permanently out of tobacco tax. Victoria (1987) and South Australia (1988) outlawed intra-state tobacco sponsorships. Sport in general and other health promotion causes are better off financially as a result. Special foundations have been created, using tobacco levies to fund all kinds of sport (annual income $23 million in Victoria, $8 million in South Australia). If this option is adopted in New Zealand, the Hillary Commission would consider itself the appropriate funding channel, and the Toxic Substances Board supports this view.

12.2 Positive Aspects

By eliminating advertising:

1) Official endorsement of tobacco smoking would be greatly reduced.

2) Young people would receive more consistent and beneficial messages about tobacco from adult society.

3) Health education for young people on the dangers of smoking would not be drowned out by skilful tobacco adverstising.

4) Peer pressure to smoke would no longer be fuelled by advertising images.

Peer pressure is rated as a most important influence on young people beginning to smoke. It seems reasonable to suggest that tobacco advertising stocks young minds with upmarket, 'cool' or adult images of smoking and that this bolsters peer pressure to smoke.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

5) The percentage of teenagers who smoke would tend to decrease

The enhanced falls in national tobacco consumption per adult seen in total advertising ban countries, suggest that,other factors such as price and incomes remaining unaltered, the elimination of tobacco promotion will accelerate the rate of decline in teenage smoking also, below what they otherwise would have been.

6) Tobacco consumption and smoking would permanently decrease.

The fall amongst present smokers is estimated at 7 percent. Nine-tenths of the fall would occur in the first five months after advertising stops, provided other factors such as price and incomes remain untouched.[2] This initial effect may be slower if point-of-sale signage were permitted to remain for several years.

These estimates do not include the future effects on young people who have not yet begun smoking.

7) Health improvements are substantial, both short and long term

<u>The gains are shortterm as well as longterm</u>

People commonly assume that the health gains would be longterm only. In fact, most of the gain begins in the short-term and follows through to longterm gains, particularly when tobacco consumption falls in a country such as New Zealand or those other OECD countries where smoking causes premature death mainly through diseases of the arteries of the heart and other arteries. In these countries, smoking is exerting its effect on people whose arteries are already dangerously narrowed because of their diet having exerted a gradual effect over previous decades.
The gains to health following the reduced smoking associated with an advertising ban will be very definite for some people, and the benefits are likely to show in a lower coronary death rate sooner than many would credit. For example, in smokers the excess mortality risk from heart attacks due to their smoking reduces by 23 percent within five years of quitting.[3]

<u>The effect of a 7 percent fall in tobacco consumption on coronary deaths.</u>

To predict the effect of an advertising ban fall in tobacco consumption we turn to the United States, to the largest such study in the world, the Framingham heart study, which has followed the fate of a whole town for decades. Knowing that risks are much the same for women as for men in middle age,[4] and assuming that blood pressure and blood cholesterol for the population stays the same, *premature deaths in New Zealand from heart disease in the age group 35 to 64 are expected to decrease by at least 70 per year, the averted deaths being spread over the following six years.*[5] This decrease in mortality, assuming blood pressure and diet remain the same, will extend its benefits to those entering this age group at age 35 each year.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

This severely underestimates the gains from 7 percent less smoking, because

(1) it does not include coronary deaths due to smoking in the next age group, between age 65-74 years, at which age coronary disease is much more common, but for which the Framingham study has no data as yet,

(2) coronary deaths only make up about a quarter of the 4000 deaths per year from smoking. Not counted are the smoking deaths due to other causes (see 2.3.1),

(3) passive smoking deaths due to heart disease, which should also be counted, are not allowed for - these too would diminish if smoking decreases.

Although we cannot use observations on whole populations to predict death rates (for such predictions, a knowledge of individual smoking habits of the population studied are usually required), observation of the fate of the population throws important light on the likely speed and the size of the consequences of reducing smoking.

With respect to lung cancer deaths, according to the known decline in excess mortality from lung cancer for smokers who quit, which more than halves in five to nine years,[6] a lower level of tobacco consumption would begin *to influence these rates in a downward direction within six years.* As deaths attributable to smoking amount to 15 percent of all deaths and over 4,800 years of life lost per annum,[7] the life expectancy of men and women, and particularly Maori, is likely to be favourably improved by any reduction in tobacco consumption.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

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1 Meads, C. a Wellington economist, in oral submission to the Board's Tobacco Subcommittee. Based on his Victoria University Economics Department thesis paper Meads, C. *An empirical study of the effects of advertising, prices and income on total cigarette sales in New Zealand: 1973-86*. unpublished, 1988.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

APPENDIX 1
EVIDENCE THAT SMOKING CAUSES DISEASE

Evidence is presented here in support of the four disease warnings currently required in rotation on all cigarette packets.

Evidence that smoking causes fatal diseases

Persons affected

Over 4000 deaths in New Zealand each year are estimated to be due to smoking-caused fatal diseases.[1]

Official support

The eleven royal specialist medical colleges and faculties in New Zealand, wrote to the Minister of Health in 1985: 'You will be aware that cigarette smoking has been identified as the chief preventable cause of death in New Zealand.'[2]

These recommendations are based in turn on over 250 population studies. Over 20 million person years have been observed and reported from many countries in reputable scientific journals since the 1950s. The studies have been summarised in the special reports of the Royal College of Physicians since 1962, and of the United States Surgeon General since 1964.

Evidence

Professor Robert Beaglehole of the Auckland School of Medicine, in reply to industry viewpoints, stated to the Subcommittee that

> The statement that smoking is the cause of death for a large number of illnesses is based not on opinion and belief, as asserted in one of the Tobacco Institute submissions, but on a wide range of evidence: human and animal, clinical and epidemiological, observational and experimental, and after allowing for other factors at work. It is now inconceivable that the associations demonstrated could be explained by genetic or psychosocial factors.
>
> The fact that the average age of death for smoking caused deaths is greater than the average for all causes [as noted by the Tobacco Institute[3]] does not indicate that smoking has a beneficial effect on the number of years of working life contributed to the economy. All it indicates is that the risk of dying from a smoking caused disease increases markedly with increasing age, that is with increasing duration of smoking.

Studies on millions of smokers and nonsmokers show, in many different populations, that tobacco smokers have much higher death rates compared to nonsmokers in the same population.

The ten major prospective studies all give a fairly uniform 70 percent increased death risk for smokers compared with nonsmokers.

The increased risk for smokers versus nonsmokers is true for both men and women, for different countries, different races, climates and occupations.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

The effect is dose related. The greater the number of cigarettes smoked, the greater the risk. For those who stop smoking, risk reverts, after about fifteen years, to that of a nonsmoker.

Pipe and cigar smokers have a small definite increased overall mortality risk compared to nonsmokers. Again, this is dose related.

Evidence that smoking causes lung cancer

Persons directly affected

Smoking causes nearly 1000 premature deaths due to lung cancer per year in New Zealand.[4]

Official support

'Cigarette smoking is the main cause of lung cancer in both men and women'.[5]

'The major cause of the disease (lung cancer) is tobacco smoking, primarily of cigarettes. The proportion of lung cancer attributable to smoking is of the order of 90 percent'.[6]

Evidence

Biological basis: Cigarette, cigar and pipe smoke tars are carcinogenic to mice skin.[7] One of the most powerful chemicals in tobacco smoke, the nitrosamine NNK, selectively causes lung cancer in rats, mice and guinea pigs. One milligram of NNK injected once is sufficient for this.[8]

Evidence from different populations: Cigarette smoking has been followed by increased lung cancer death rates in men and women, in different races, age groups, occupations and countries. In New Zealand, 94 percent of registered lung cancer patients are or have been smokers.[9]

Table A1 Main studies on the relationship between smoking and (lung) cancer

Study	Followed up Persons	Years	Risk of premature death for smokers of 1+packsdaily (nonsmokers' risk =1.0)
American Cancer Society (ACS)			
9 states	204,547	5	18 times
ACS, 25 states	1,078,894	5	13 times
Canadian study	207,397	6	17 times
US Veterans	293,958	16	17 times
British doctors	34,440	20	13 times
California study	68,153	5-8	10 times
Swedish study	55,074	10	14 times
Japanese study	122,261	16	6 times
ACS 1982-86	600,000	4	22 times for men
	600,000	4	12 times for women

Sources: Evaluation of the carcinogenic risk of chemicals to humans. *Tobacco smoking.* (Vol38) International Agency for Research on Cancer, Lyon, 1985 pp. 215-16.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Reducing the Health Consequences of Smoking: 25 years of progress. A report of the Surgeon General, 1989. U.S. Department of Health and Human Welfare, Table 8, p. 153

Lung cancer risk rises with the amount smoked: The risk is increased for those who smoke more cigarettes per day, inhale more deeply, smoke from a younger age, smoke for more years, smoke higher tar cigarettes. The heavier smokers have much greater risks. Twenty-five cigarettes a day increases the risk - about twenty-five times over that of a nonsmoker.

Decrease of risk after stopping smoking: The risk of lung cancer halves after five years and slowly returns over fifteen years to that of a nonsmoker. Stopping avoids about 80 percent of the excess risk that would have accrued with continued smoking.[10]

Pipe and cigar smokers: Lung cancer death risks are greater than for nonsmokers. The effect is dose related.[11]

Comment

Dr Sharon Boyse, senior scientific adviser for British American Tobacco, the largest free enterprise tobacco firm in the world (judged on sales) appeared before the Subcommittee. She implicated a wide range of factors as causing lung cancer, but did not include tobacco or cigarettes in her long list. In reply, the Board's consultant, Dr Robert Beaglehole, Professor of Community Health in the Auckland School of Medicine, stated:

> Briefly, there is no dispute that cigarette smoking is not the only cause of lung cancer. This should not obscure the main fact: ***in countries like New Zealand, smoking is the most important cause of lung cancer, responsible for approximately 90 percent of all cases each year. The other postulated causes pale into insignificance in comparison with smoking.*** Particularly significant in the New Zealand context are, firstly, the very high rates in New Zealand Maori women and, secondly, the esacalating rate in New Zealand women in general.

Evidence that smoking causes heart disease

Persons directly affected

Smoking causes over 1000 premature coronary deaths yearly in New Zealand.[12]

Official support

> 'Smoking is causally related to coronary heart disease in the common sense of that idea and for the purposes of preventive medicine'.[13]

Evidence

Biological basis: Dr Boyse on behalf of British American Tobacco stated that there are no known biological mechanisms to explain how cigarette smoking might cause heart disease. Professor Beaglehole disagreed, pointing out that (1) smokers have increased atheroma (diseased artery linings), (2) smoke contains nicotine and carbon monoxide, both with known effects on the heart and circulation, (3) cigarette smoking also raises blood lipid levels, and affects clotting (and hence can induce sudden coronary thrombosis - a blockage of the arteries of the heart by blood and clot).

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

increased coronary artery disease death rates in men and women, in different races, countries, ag groups and occupations (Table A1.2).

Table A1.2 Age adjusted relative risks of death from coronary heart disease in majo cohort studies on the effects of tobacco smoking

Study	Deaths in study population	Relative risk of death for smokers (non-smokers' relative risk = 1.0)
American Cancer Society (ACS)	34,974 men	1.6
Canadian study	3,405 men	1.6
British doctors	3,191 men	1.6
ACS 25 states	10,771 men	1.2-2.8
US Veterans	34,874 men	1.6
California	1,718 men	1.6
Swedish	916 men	1.7
Japanese	3,351 men	1.7
	2,653 women	1.8
Swiss doctors	280 men	1.3-2.2
ACS 1982-86	5,000+ men	2.8 (age 35-64)
ACS 1982-86	10,000+ women	3.0 (age 35-64)

Source: *Reducing the health consequences of smoking. 25 years of progress. A report of the Surgeon General.* U.S. Department of Health and Human Welfare, Table 8, p.15

Dr Boyse for BAT stated that the decline in coronary disease mortality bears no relationship to the decline in cigarette smoking.

In reply, Professor Beaglehole, a member of the World Health Organisation's expert committee o the prevention of cardiovascular disease, said that was untrue. In New Zealand, the decline in per capita consumption of tobacco predated the onset of the decline in coronary heart disease mortality (Figure A1.2).

Coronary heart disease mortality peaked in 1968; tobacco consumption per adult peaked befo this in 1963, and again in 1966 (Figure A1.2). If, however, allowance is made for the changi amount of tobacco inserted in manufactured cigarettes, the amount of tobacco smoked per adu actually peaked earlier still, in 1955.[14]

Fig A1.2 Coronary death rate in men, ages 45-54 yrs; Tobacco sold per adult, Ne Zealand, 1960-86

(B&W line graph)

Source: Tobacco and cigarettes released for sale. In Monthly abstract o statistics. National Health Statistics, Department of Statistics.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Dr Boyse admitted that smoking is associated with coronary heart disease, but that other factors and, in particular, diet are more important. Professor Beaglehole pointed out to the Subcommittee that the New Zealand epidemic of coronary heart disease is undoubtedly multifactorial in origin. Dietary factors, in particular a high consumption of saturated animal fat, are the underlying cause of coronary heart disease in New Zealand. For smokers, however, the risk of premature death by heart attack is at least at double the risk of nonsmokers. There is thus a clear dose-response relationship.

Industry consultants mentioned one or two studies which failed to find increased risks of heart disease in smokers.

Professor Beaglehole, however, pointed out:

> The Surgeon General's criteria for causality do not have to be met in every case. It is the overwhelming weight of the evidence when viewed in total that indicates the causality of the relationship between cigarette smoking and coronary heart disease and lung cancer.

Smoking causes a large proportion of heart disease: Cigarette smoking is a major cause of coronary heart disease, causing 30 percent of all coronary heart disease in the United States.[15] In New Zealand, smoking is responsible for at least 25 percent of all deaths from heart disease.[16]

The risk increases with the amount smoked: Risk increases with the number of cigarettes smoked, degree of inhalation and years smoked. Heavy smokers have a two to three times greater risk of death than nonsmokers, and have four times the coronary disease rate of nonsmokers.

Reversal of risk: On cessation of smoking, the coronary death risk for these ex-smokers declines.

Filters and low tar cigarettes: On present evidence, these do not clearly cause less heart damage than plain or high tar cigarettes.

Evidence that smoking damages your lungs

Persons directly affected

Over 800 deaths per year in New Zealand are attributable to bronchitis and emphysema.[17]

Official support

> 'Cigarette smoking is a major cause of chronic obstructive lung disease in the United States for both men and women. The contribution of cigarette smoking to chronic obstructive lung disease outweighs all other factors'.[18]

Evidence

Biological basis: Tobacco smoke, because of chemicals in it, such as hydrogen cyanide, interferes with the action of the protective cilial hairs on the surface cells of airway passages. Tobacco smoke at the same time brings particulate matter (tar) into the lung. Obstruction and infection occurs in the small airways. Lung function and structure are repeatedly damaged.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Evidence of increased risk from different populations: Cigarette smoking has been followed by increased chronic obstructive lung disease death rates in people of different sex, race, country, age group and occupation, studied for more than 15 million person years of observation. Postmortem studies show mild to moderate emphysema in most smokers, but rarely in nonsmokers. A small percentage of smokers develop severe emphysema; this minority includes a disproportionate number of heavy smokers.

The more a person smokes, the greater the risk: Damage to smokers' lungs seen at postmortem is greater for those who smoke more, for those who inhale or who smoke for longer.

Reversal of risk on cessation of smoking: Cessation leads to partial improvement.

Pipes, cigars and low tar cigarettes: Pipe and cigar smokers have damaged lung function and structure compared with nonsmokers. Mortality rates for bronchitis and emphysema are higher for pipe and cigar smokers than for nonsmokers; smokers have more respiratory symptoms and illness than nonsmokers.[19] It is unclear whether low tar cigarettes protect from lung disease.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

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6

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2 Letter from the Royal Specialist Colleges to the Minister of Health (NewZealand), 1985.

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5 *Smoking and health: a report of the Surgeon General* U.S. Department of Health, Education and Welfare, 1979, pp.5-31.

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REPRINT

C-51

Second Session, Thirty-third Parliament,
35-36-37 Elizabeth II, 1986-87-88

THE HOUSE OF COMMONS OF CANADA

BILL C-51

An Act to prohibit the advertising and promotion and respecting the labelling and monitoring of tobacco products

AS PASSED BY THE HOUSE OF COMMONS
MAY 31, 1988

29396

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2nd Session, 33rd Parliament,
35-36-37 Elizabeth II, 1986-87-88

THE HOUSE OF COMMONS OF CANADA

BILL C-51

An Act to prohibit the advertising and promotion and respecting the labelling and monitoring of tobacco products

Her Majesty, by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:

SHORT TITLE

Short title

1. This Act may be cited as the *Tobacco Products Control Act*.

INTERPRETATION

Definitions

2. (1) In this Act,

"analyst" *analyste*

"analyst" means a person designated as tobacco product analyst pursuant to section 11;

"distributor" *exportateur*

"distributor" means a person engaged in the business of selling tobacco products otherwise than at retail only, and includes a manufacturer or importer thereof;

"inspector" *inspecteur*

"inspector" means a person designated as tobacco product inspector pursuant to section 11;

"manufacturer" *fabricant*

"manufacturer" includes any corporation that is associated with a manufacturer;

"Minister" *ministre*

"Minister" means the Minister of National Health and Welfare;

"package" *emballage*

"package" means any pack, carton, wrapping or other container in which tobacco products are customarily sold at retail;

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

"prescribed" *Version anglaise seulement*

"prescribed" means prescribed by regulations made under this Act;

"retailer" *détaillant*

"retailer" means a person engaged in any business that includes the sale of tobacco products at retail;

"tobacco product" *produit du tabac*

"tobacco product" means any product manufactured from tobacco and intended for use by smoking, inhalation or mastication, and includes nasal and oral snuff;

"trade mark" *marque*

"trade mark" includes any trade mark whether or not it is registered or registrable as such under the *Trade Marks Act*, and any recognizable variation thereof.

Associated corporations

(2) For the purposes of this section, two corporations are associated with each other if one is controlled by the other or if both are controlled by the same person.

PURPOSE

Purpose of Act

3. The purpose of this Act is to provide a legislative response to a national public health problem of substantial and pressing concern and, in particular,

(*a*) to protect the health of Canadians in the light of conclusive evidence implicating tobacco use in the incidence of numerous debilitating and fatal diseases;

(*b*) to protect young persons and others, to the extent that is reasonable in a free and democratic society, from inducements to use tobacco products and consequent dependence on them; and

(*c*) to enhance public awareness of the hazards of tobacco use by ensuring the effective communication of pertinent information to consumers of tobacco products.

ADVERTISING

Advertisers

4. (1) No person shall advertise any tobacco product offered for sale in Canada.

Communications media

(2) No person shall, for consideration, publish, broadcast or otherwise disseminate,

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Retail displays

5. (1) Notwithstanding section 4, a retailer may

(*a*) expose tobacco products for sale at the retailer's place of business;

(*b*) post in that place, in the prescribed form, manner and quantity, signs that indicate, otherwise than by their brand names or trade marks, the tobacco products offered for sale and their prices;

(*c*) where the retailer's name or trade name contains any word or expression signifying that tobacco products are sold by the retailer, employ that name or trade name, otherwise than in association with a tobacco product, for the purpose of advertising the retailer's business, except by means of a radio or television transmission; and

(*d*) display at the retailer's place of business, at any time before January 1, 1993, an advertisement or portion thereof

(i) that was displayed in that place before January 25, 1988, or

(ii) that the retailer is obliged to display under the terms of a contract entered into before January 25, 1988, other than a term allowing for the extension or renewal of the contract after that day.

Vending machines

(2) Notwithstanding section 4, a person who operates a vending machine that dispenses tobacco products may identify or depict those products and their prices on the exterior of the vending machine in the prescribed form and manner.

PROMOTION

Permitted sponsorships

6. (1) Notwithstanding section 4 and subsection 8(1) but subject to subsection (2) of this section, the full name of a manufacturer or importer of tobacco products and, where required by the terms of a contract entered into before January 25, 1988, the brand name of a tobacco product, may be used, otherwise than in association with a tobacco product, in a representation to the public

(*a*) that promotes a cultural or sporting activity or event; or

(*b*) that acknowledges financial or other contributions made by the manufacturer or importer of the tobacco product toward such an activity or event.

Monetary limits

(2) Where, in any calendar year, a manufacturer or importer of tobacco products makes financial or other contributions toward cultural or sporting activities or events in respect of which brand names of those products are used, the value of such contributions, determined in accordance with the regulations, shall not exceed the value, so determined, of the contributions made by the manufacturer or importer toward cultural or sporting activities and events in 1987.

Distribution

7. (1) No distributor shall distribute tobacco products in the absence of consideration therefor, or furnish tobacco products to any person for the purpose of their subsequent distribution without consideration.

Rewards and contests

(2) No person shall offer any gift or cash rebate or the right to participate in any contest, lottery or game to the purchaser of a tobacco product in consideration of the purchase thereof, or to any person in consideration of the furnishing of evidence of such a purchase.

Trade marks on non-tobacco goods

8. (1) No manufacturer or importer of tobacco products who is entitled to use any trade mark in association with those products, and no person acting with the concurrence or acquiescence of such a manufacturer or importer, shall

(*a*) apply the trade mark, in any form in which it appears on packages of the product that are sold in Canada, to any article other than a tobacco product or a package or container in which a tobacco product is sold or shipped, or

(*b*) use the trade mark in any such form for the purpose of advertising any article other than a tobacco product or any service, activity or event,

notwithstanding that the manufacturer or importer is, but for this Act, entitled to use the trade mark in association with that article, service, activity or event.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

Sale of non-tobacco goods

(2) No person shall distribute, sell, offer for sale or expose for sale any article, other than a tobacco product or a package or container in which a tobacco product is sold or shipped, that bears a trade mark of a tobacco product in any form in which it appears on packages of the tobacco product that are sold in Canada.

Defence

(3) Subsections (1) and (2) do not apply in respect of a trade mark if in 1986 tobacco products and other articles bearing that trade mark were sold at retail in Canada and the retail value of those other articles estimated in accordance with the regulations was greater than one-quarter of the retail value of those tobacco products so estimated.

Existing and future goods

(4) Subsection (2) does not apply in respect of the distribution or sale before January 1, 1993 of an article manufactured before April 30, 1987, or ordered before that date from the manufacturer or supplier of the article otherwise than by the placing of a standing order that requires confirmation or is subject to cancellation after that date.

LABELLING

Health warning

9. (1) No distributor shall sell or offer for sale a tobacco product unless

(*a*) the package containing the product displays, in accordance with the regulations, messages pertaining to the health effects of the product and a list of toxic constituents of the product and, where applicable, of the smoke produced from its combustion indicating the quantities of those constituents present therein; and

(*b*) if and as required by the regulations, a leaflet furnishing information relative to the health effects of the product has been placed inside the package containing the product.

Extraneous information

(2) No distributor shall sell or offer for sale a tobacco product if the package in which it is contained displays any writing other than the name, brand name and any trade marks of the tobacco product, the messages and list referred to in subsection (1), the label required by the *Consumer Packaging and Labelling Act* and the stamp and information required by sections 203 and 204 of the *Excise Act*.

Existing rights saved

(3) This section does not affect any obligation of a distributor, at common law or under any Act of Parliament or of a provincial legislature, to warn purchasers of tobacco products of the health effects of those products.

REPORTING

Constituents

10. (1) Subject to any regulations made under paragraph 17(*h*), every manufacturer or importer of tobacco products of a class prescribed for the purposes of this subsection shall provide to the Minister, in the prescribed form and manner and at the prescribed intervals, reports identifying the constituents of those products and, where applicable, of the smoke produced from their combustion and indicating the quantities of those constituents present therein.

Product volume

(2) Every manufacturer or importer of tobacco products of a class prescribed for the purposes of this subsection shall provide to the Minister, in the prescribed form and manner and at the prescribed intervals, reports indicating the quantity of those tobacco products manufactured or imported by that manufacturer or importer and the quantity thereof sold by that manufacturer or importer.

Information re sponsorships

(3) Every manufacturer of tobacco products shall, within the prescribed period following the end of each calendar year, provide the Minister with the prescribed information for the determination of the monetary value of support referred to in subsection 6(2) that was provided by the manufacturer in that year.

Information re signs

(4) Every manufacturer or importer of tobacco products shall

(*a*) within the prescribed period following the coming into force of this Act, provide the Minister with the prescribed information for the determination of the expenses of the manufacturer or importer referred to in paragraph 4(5)(*a*); and

(*b*) within the prescribed period following the years 1989 and 1990, provide the Min-

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ister with the prescribed information for the determination of the amounts referred to in paragraphs 4(5)(*a*) and (*b*), respectively, that were expended by the manufacturer or importer.

ENFORCEMENT

Inspectors and analysts

11. (1) The Minister may designate as a tobacco product inspector or as a tobacco product analyst any person who, in the opinion of the Minister, is qualified to be so designated.

Production of certificate

(2) The Minister shall furnish every inspector with a certificate of the inspector's designation as such and, on entering any place described in subsection 12(1) or 13(1), an inspector shall, on demand, produce the certificate to the person in charge thereof.

Search

12. (1) An inspector with a warrant issued under subsection (2) may at any reasonable time enter and search any place in which the inspector believes on reasonable grounds there is any thing by means of or in relation to which any provision of this Act has been contravened, and may seize and detain any such thing.

Authority to issue warrant

(2) Where on *ex parte* application a justice of the peace is satisfied by information on oath that there are reasonable grounds to believe that there is in any place referred to in subsection (1)

(*a*) any thing by means of or in relation to which any provision of this Act has been contravened, or

(*b*) any thing that there are reasonable grounds to believe will afford evidence with respect to the commission of an offence under this Act,

the justice of the peace may issue a warrant under his hand authorizing the inspector named therein to enter and search that place and to seize and detain the thing, subject to any conditions that are specified therein.

Use of force

(3) In executing a warrant issued under subsection (2), the inspector named therein shall not use force unless the inspector is accompanied by a peace officer and the use of force has been specifically authorized in the warrant.

Inspection

13. (1) An inspector may at any reasonable time enter any place other than a private dwelling place in which the inspector believes on reasonable grounds that there is any equipment or material used to determine, for the purposes of subsection 10(1), the quantities of constituents of tobacco products or of the smoke produced from them, or that there are records or data relating to the reports required by section 10, and may

(*a*) examine any such equipment or material or any tobacco product found in that place;

(*b*) open and examine any receptacle or package found therein that the inspector has reason to believe contains any such material or any tobacco product;

(*c*) take samples of any such material or any tobacco product; and

(*d*) examine any books, records, documents or electronic data that on reasonable grounds the inspector believes contain any information relevant to the enforcement of this Act, and make copies thereof or extracts therefrom.

Seizure

(2) Whenever an inspector, in the course of an inspection under subsection (1), believes on reasonable grounds that any provision of this Act has been contravened, the inspector may seize and detain any thing in relation to which or by means of which the inspector believes on reasonable grounds that the contravention occurred.

Assistance to inspectors

14. (1) The owner or person in charge of a place entered by an inspector pursuant to section 12 or 13 and every person found therein shall give the inspector all reasonable assistance to enable the inspector to carry out the inspector's duties and functions under this Act and shall furnish the inspector with such information with respect to the administration of this Act as the inspector reasonably requires.

Obstruction of inspectors

(2) No person shall obstruct or hinder an inspector in carrying out duties or functions under this Act.

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Analysis

15. (1) An inspector may submit to an analyst for analysis or examination any thing seized under section 12 or 13.

Certificate

(2) An analyst may, after making an analysis or examination, issue a certificate setting forth the results of the analysis or examination.

Certificate of analyst

(3) Subject to subsections (4) and (5), in any prosecution for an offence under subsection 9(1) or 10(1), a certificate of an analyst stating that the analyst has analysed or examined any thing submitted to the analyst and stating the results of the analysis or examination is admissible in evidence and in the absence of evidence to the contrary is proof of the statements contained in the certificate without proof of the signature or official character of the person appearing to have signed the certificate.

Attendance of analyst

(4) The party against whom a certificate of an analyst is produced pursuant to subsection (3) may, with leave of the court, require the attendance of the analyst for the purposes of cross-examination.

Notice

(5) No certificate shall be received in evidence pursuant to subsection (3) unless the party intending to produce it has, before the trial, given to the party against whom it is intended to be produced reasonable notice of such an intention together with a copy of the certificate.

Detention of things seized

16. (1) Any thing seized pursuant to section 12 or 13 shall not be detained after the expiration of ninety days after the day of seizure unless before that time proceedings have been instituted in respect of the contravention in which case it may be detained until the proceedings are finally concluded.

Disposition with consent of owner

(2) Where the Minister has custody of any thing referred to in subsection (1), the Minister may with the written consent of the owner dispose of it as the Minister sees fit.

Where consent deemed given

(3) Where the Minister, by registered letter or by a demand served personally, requests the owner of a thing referred to in subsection (2) to repossess it and the owner fails to do so within thirty days after receipt of the request, the owner shall be thereupon deemed to have given the consent mentioned in subsection (2).

Order for forfeiture

(4) A judge of a superior, county or district court of the province in which any thing was seized under this Act may, on the application of an inspector and on such notice to such persons as the judge directs, order that the thing and anything else of a similar nature found therewith be forfeited to Her Majesty to be disposed of as the Minister directs, if the judge finds, after making such inquiry as the judge considers necessary, that the thing is one by means of or in relation to which any of the provisions of this Act were contravened.

REGULATIONS

Regulations

17. The Governor in Council may make regulations

(*a*) exempting a tobacco product from the application of sections 4 and 7 where, in the opinion of the Governor in Council, that product is likely to be used as a substitute for other tobacco products and poses less risk to the health of users than those other products;

(*b*) respecting the determination of the amounts and expenses referred to in paragraphs 4(5)(*a*) and (*b*);

(*c*) prescribing, in respect of any tobacco product, the content, position, configuration, size and prominence of the health warnings referred to in paragraph 4(5)(*c*);

(*d*) respecting the determination of the value of contributions referred to in section 6;

(*e*) respecting the manner of estimating the retail value of tobacco products and other articles sold in 1986 for the purposes of subsection 8(3);

(*f*) prescribing, in respect of any tobacco product, the content, position, configuration, size and prominence of the messages and list of toxic constituents referred to in paragraph 9(1)(*a*);

(*g*) requiring leaflets furnishing information referred to in paragraph 9(1)(*b*) to be placed inside packages of a tobacco prod-

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uct and prescribing their content, form and manner of placement in those packages;

(*h*) exempting from the application of subsection 10(1) persons whose sales of tobacco products of any class constitute less than a prescribed proportion of the total sales of tobacco products of that class;

(*i*) requiring manufacturers and importers of tobacco products to maintain such records as the Governor in Council considers necessary for the enforcement of sections 9 and 10; and

(*j*) prescribing anything that by this Act is to be prescribed.

OFFENCES AND PUNISHMENTS

Offence and punishment

18. (1) Every person who contravenes section 4, 7, 8, 9 or 10

(*a*) is guilty of an offence punishable on summary conviction and is liable

(i) for a first offence under any of those sections, to a fine not exceeding two thousand dollars or to imprisonment for a term not exceeding six months, or to both, and

(ii) where the person has previously been convicted of an offence under any of those sections, to a fine not exceeding five thousand dollars or to imprisonment for a term not exceeding six months, or to both; or

(*b*) is guilty of an indictable offence and is liable

(i) for a first offence under any of those sections, to a fine not exceeding one hundred thousand dollars or to imprisonment for a term not exceeding one year, or to both, and

(ii) where the person has previously been convicted of an offence under any of those sections, to a fine not exceeding three hundred thousand dollars or to imprisonment for two years, or to both.

Idem

(2) Every person who contravenes subsection 6(2) is guilty of an offence punishable on summary conviction and is liable

(*a*) for a first offence, to a fine not exceeding ten thousand dollars or to imprisonment for a term not exceeding six months, or to both; or

(*b*) for a second or subsequent offence, to a fine not exceeding fifty thousand dollars or to imprisonment for a term not exceeding one year, or to both.

Offence and penalty

(3) Every person who contravenes section 14 or any regulations made under paragraph 17(*i*) is guilty of an offence punishable on summary conviction and is liable to a fine not exceeding ten thousand dollars.

Time limit

19. (1) A prosecution in respect of an offence under this Act, other than a prosecution under paragraph 18(1)(*b*), may not be instituted later than twelve months after the time when the subject-matter of the prosecution arose.

Venue

(2) A prosecution for an offence under this Act may be instituted, heard, tried and determined by a court in any territorial jurisdiction in which the accused carries on business regardless of where the subject-matter of the prosecution arose.

Exemption need not be pleaded

(3) No exception, exemption, excuse or qualification prescribed by law is required to be set out or negatived, as the case may be, in an information or indictment for an offence under this Act or under section 421, 422 or 423 of the *Criminal Code* in respect of an offence under this Act.

Burden of proof on accused

(4) In any prosecution for an offence referred to in subsection (3), the burden of proving that an exception, exemption, excuse or qualification prescribed by law operates in favour of the accused is on the accused and the prosecutor is not required, except by way of rebuttal, to prove that the exception, exemption, excuse or qualification does not operate in favour of the accused, whether or not it is set out in the information or indictment.

COMING INTO FORCE

Coming into force

20. This Act shall come into force on January 1, 1989.

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over 18 free market advanced economies, according to policy on tobacco promotion, and annual rates of change in real tobacco prices and in real income per capita 1970-1986

Country and year ban enforced	Years studied	Tobacco consumption g/adult			Real tobacco price			Real personal income per capita[r]		
	from to	from	to	Change % p.a.	from	to	Change % p.a.	from	to	Change % p.a.
Complete enforced tobacco advertising ban										
Iceland[w] 1971	70-83	3175	3049	-0.3	84	82	-0.2	66[p]	106[p]	+ 4.7
Finland 1978	77-86	2128	2017	-0.6	95.5	109	+1.7	91	107	+ 1.9
Norway 1975	74-86	2086	1927	-0.6	116	133	+1.4	90	112	+ 2.0
Portugal 1983	83-86	2068	1750	-5.1	97.5	107	+3.2	92[h]	91[h]	- 0.3
Promoted in few media										
Belgium	80-86	3183	3270	+0.5	100	88	-2.0	100	100	- 0.0
France	76-86	2352	2348	-0.02	102.5	103.5	+0.1	98	100	+ 0.1
Italy, 1983	83-86	2306	2227	-1.1	117	116	-0.3	102	99	- 1.1
New Zealand	70-86	3114	2304	-1.6	131	132	+0.02	63.5	97	+ 3.3
Singapore	70-86	2265	2261	-0.01	117	110[5]	-0.4	68[p]	112[p]	+ 4.0
Sweden	70-86	1921	1879	-0.1	103	100	-0.2	78	106.5	+ 2.4
Promoted in most media										
Australia	70-86	3333	2375	-1.8	92	126	+2.3	96.5	98	+ 0.1
Austria	70-86	2500	2615	+0.3	109	114	+0.3	147	99	- 2.0
Belgium	70-79	3436	3176	-0.8	82	103	+2.8	142	106	- 2.8
Canada	70-86	3990	3253	-1.2	111	159	+2.7	81	107	+ 2.0
Denmark	70-86	2537	2542[5]	+0.01	129	101.5	-1.3	91	109	+ 1.3
FRG; W Germany	70-86	2678	2625	+0.1	107.5	109	+0.1	83	98	+ 1.1
France	70-75	2181	2412	+2.1	134	104	-4.5	92[71]	98	+ 1.6
Italy	70-82	1816	2289	+2.2	191	114	-3.35	75	104	+ 3.1
Ireland	70-86	3281	2887	-0.8	138	131	-0.3	96	80	- 1.0
Netherlands	70-86	3355	3021	-0.6	117	115	-0.1	93	84	- 0.6
Switzerland	70-86	3789	2865	-1.5	na	na	na	110.5	101	- 0.5
United Kingdom	70-86	3377	2300	-2.0	114	138	+1.3	96	110	+ 0.9
United States	70-86	3936	3187	-1.2	102	102	0	90.5	108	+ 1.2
Promoted in all media										
Greece	70-86	2570	3999	+3.5	80	121	+3.2	97[75]	91	- 0.6
Japan[c]	70-86	2826	3329	+1.1	139	111	-1.25	77	94	+ 1.4
Portugal	70-82	1451	2018	+3.3	82	101	+2.5	94	99	+ 0.6
Spain	70-86	2346	2644	+0.8	130	121	-0.45	66	119	+ 5.0
Turkey	70-86	2064	2020	-0.1	na	na	na	na	na	na

Key
- [r] Real retail sales index per capita, all goods, in constant currency, indexed to a base of 1980=100.
- [p] Private consumption all goods constant $ per capita, 1980=100
- [h] Hourly earnings in manufacturing, constant $, 1980 =100.
- [c] Manufactured cigarettes only [w] by weight not pieces
- [5] Refers to 1985 data. [71] Refers to 1971 data [75] 1975 data

Sources : Official statistical abstracts of each country, United Nations *Industrial statistics yearbook* (UN), *Demographic yearbook* (UN), *Tobacco Quarterly* (Commonwealth Secretariat), *National Accounts*, Organisation for Economic Cooperation (OECD), *Measuring Health Care* OECD 1985 and UN *National Accounts*, *International Financial Statistics* (International Monetary Fund), *World Trade Annual* (UN), US Dept of Agriculture Foreign Agricultural Service, *FT circulars*.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

promotion policy

Country	Peak Year	Tobacco for smoking, grams/adult/year 1970	1975	1980	1985	1986	1987
Total ban on tobacco promotion for health reasons							
Iceland[t]	1975	3175	3782	2757	3422	3326	3106
Finland	1974	2252	2442	2096	2034	2017	
Norway	1962	2032	2099.	2109	1909	1919	1863
Portugal	1983	1451	1827	1617	1891	1750	1895
Advertising not permitted for political reasons							
Albania[c]	1981		1175	1254	1159	1189	
Bulgaria[c]	1984		1949	2330	2661	2282	
Czechoslov.	na			2612[a]	2401	2374	
FDRGermany[c]	1986		2171	2403	2396	2408	
Hungary	1981		3120[b]	3420	3263	3246	
Poland[c]	1986	2826	3288	3529	3341	3558	
Romania[c,p]	1982		1824	2028	2107	2071	
USSR[c]	1976	1862	2215	2106	2145	2149	
Yugoslavia	1979		2534	3269	3141	3102	
Tobacco promoted in few media							
France	1985	2181	2412	2289	2422	2348	2321
Italy	1979	1816	2517	2262	2310	2227	2156
New Zealand	1964	3115	3219	2856	2493	2304	2328
Singapore	1974	2265	2919	2537	2821	2261	
Sweden	1972	1921	2040	1983	1894	1879	
Tobacco promoted in most media							
Australia	1960	3333	3287	2869	2449	2375	2240
Austria	1979	2500	2536	2687	2639	2615	
Belgium	1983	3436	3475	3183	3463	3270	3047
Canada	1966	3990	3974	3608	3394	3253	
Denmark	1973	2537	2588	2436	2542		
FRGermany	1981	2678	2859	2836	2662	2625	
Ireland	1976[x]	3281			2908	2887	
Netherlands	1979	3355	3856	3534	3049	3021	2892
Switzerland	1972	3789	2485	4073	2995	2865	
UK	1973	3377	3421	3014	2370	2300	2278
USA	1963	3936	3978	3735	3262	3187	
Tobacco promoted in all media							
Greece	1986	2570	3140	3472	3704	3999	
Japan[c]	1977	2826	3433	3409	3327	3329	
Spain	1974	2346	2374	2750	2833	2644	
Turkey	1981	2064	2346	2437	2187	2020	

Notes
[a] 1981 data
[b] 1976 data
[t] total tobacco
[p] production, not consumption
[c] manufactured cigarettes only
[x] approximate

Source: National statistical yearbooks, *Tobacco Quarterly*, *UN & OECD National accounts*, *UN Demographic Yearbooks*.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

TOBACCO ADVERTISING CONTROL SCORE

A country can be scored annually for the number of main media in which tobacco promotion is banned, restricted, or blunted by health warnings. The score indicates governmental policy towards tobacco promotion.

Choose one score from each box and add.	Possible Score	Score for NZ, 1989
RADIO tobacco advertising permitted	= 0	
or, permitted with warnings	= 0.5	
or, no tobacco advertising on radio	= 1.0	*1.0*
TELEVISION tobacco advertising permitted	= 0	
or, permitted with warnings	= 0.5	
or, no tobacco advertising on TV	= 1.0	*1.0*
CINEMA tobacco advertising permitted	= 0	
or, no advertising in cinema	= 1.0	*1.0*
OUTDOOR POSTERS permitted, with/without warnings	= 0	
or, outdoor advertising cut 50% in constant$	= 0.5	
or, outdoor tobacco advertising banned	= 1.0	*1.0*
SHOPS Tobacco ads. permitted with or without health warnings	= 0	*0*
or, Shop signs severely restricted	= 0.5	
or, No advertising at point of sale	= 1.0	
PRESS & MAGAZINES		
Tobacco advertising without any controls	= 0	
or, Tobacco advertising in press, magazines with varied warnings & content control	= 1.5	*1.5*
or, with varied warnings, no content control	= 1.0	
or, with same warning required on all ads.	= 0.5	
or, with content controlled	= 0.5	
or, No tobacco ads. permitted	= 2.0	
CIGARETTE PACKETS carry no health warning	= 0	
single or weak warning on packets	= 1.0	
strong and varied warnings on packet	= 2.0	*2.0*
SPONSORSHIP takes place	= 0	*0*
absent, banned or nonexistent	= 1.0	
ALL MEDIA maximum score	=10.0	*6.5*

Minor exceptions, such as TV cigar adverts. are ignored. For a midyear change in policy, add half the estimated change in score.
Indirect advertising If advertising is permitted of non-tobacco goods with tobacco brandnames, subtract 1.0 point.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

APPENDIX 5

DATA SOURCES

1 Tobacco consumption

Official yearbooks and monthly statistical abstracts of each country, *United Nations Industrial statistics yearbook*, United Nations (UN), *United Nations Demographic Yearbook* (UN), *Tobacco Quarterly* (Commonwealth Secretariat), *Measuring Health Care* OECD 1985, *World Trade Annual* (United Nations), US Dept of Agriculture Foreign Agricultural Service, *FT circular series.*

2 Smoking prevalence

Giezerova H. and Masironi R. Cigarette smoking in children and adolescents: World review. in *Smoking and Health 1987* ed. by M. Aoki, S. Hisamuchi, S. Tominaga. Excerpta Medica, Amsterdam. p. 601-605.

The World Cigarette Market, The 1988 International Survey. ERC Statistics International Limited, Newmarket, Suffolk.

Planning for a Smoke-free Generation Smoke-free Europe:6 World Health Organisation Office for Europe 1988.

Masironi R. and Roy L. *Cigarette smoking in young age groups. Geographic Prevalence.* World Health Organisation, Geneva. WHO/SMO/82.3

Rothwell K, Masironi R. and O'Byrne D. *Smoking in Europe* World Health Organisation, Geneva. 1987. paper WHO/SMO/EURO/87.1

Rothwell K and Masironi R. *Cigarette smoking in Developed Countries outside Europe* World Health Organisation, Geneva. paper WHO WPR/NCD/INF/2.

Australia Commonwealth Department of Health, Canberra.

Finland National Board of Health, Helsinki.

Ireland Health Education Bureau, Republic of Ireland, quoted in Uma Ram Nath. Smoking - *Third World Alert.* Oxford University Publications, London 1986.

Japan Tominaga S. *Smoking and Cancer Patterns and trends in Japan* - IARC Scientific Publications 1986 v. 74. p. 103-113

Netherlands van Reek J. Smoking behaviour in the Netherlands, a striking decrease between 1958-1982. *Hygie* v. IV 1985/4; and Nelissen JGM - Nonsmoking and children in the Netherlands in *Smoking and Health 1987* M. Aoki et al. editors, Elsevier Science Publishers 1988. page 789 Table 1.

New Zealand Census, 1976 & 1981, OTR Spectrum annual and quarterly surveys of smoking prevalence, data purchased by Department of Health.

Norway Statens Tobakkskaderad (Council on Smoking and Health). Oslo.

Sweden National Board of Health and Welfare, and National Bureau of Statistics

United States *MMWR Report*, Center for Disease Control US Dept. of Health and Human Services Sept 11, 1987.v. 36, no. 35.

United Kingdom OPCS *General Household Surveys*, reported in GHS 85/2, and in *New Society* 4 March 1988 ISSN 00286729.

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

3 Real Tobacco prices

National yearbooks in many OECD countries provide nominal tobacco price indices, which were indexed to 1980 price = 100, deflated by the consumer price index to yield a real price index, which in 1980 = 100.
National accounts OECD, dividing expenditure on tobacco products (from personal consumption tables) by consumption, to provide relative tobacco price. *Measuring health care* OECD 1985. Table F11, is also based on national accounts. *National accounts United Nations* were used for non-OECD countries.

4 Personal income

National statistical yearbooks, and *Main economic indicators, historical series 1964-83* OECD, and *Monthly series August 1988. OECD*, provide the value of retail sales of all goods as a surrogate for personal income. This is then converted to constant prices, using the consumer price index, and converted to a per capita index. *International Financial Statistics* International Monetary Fund provided personal consumption, which after conversion to a per capita index, served as an alternative indicator.

5 Consumer Price Index

Main economic indicators, historical series 1964-83 OECD, and *Monthly series August 1988. OECD*. These provided consumer price indices for OECD countries back to 1964 in most cases, indexed to 1980 prices = 100.
For other countries, statistical yearbooks provided the data.

6 Population

World Health Statistics Annual World Health Organisation (WHO), *Demographic Yearbook*, *Monthly statistical bulletin*, *World Statistics in brief*, and *Quarterly Labour Statistics*, United Nations. From these, population age 15 years and over was calculated.

7 Mortality

World Health Statistics Annuals (WHO) commencing 1964 provide age specific and age standardised mortality rates which enable valid international comparisons of lung cancer and other mortality rates.

8 Legislation and agreements controlling tobacco advertising

International Digest of Health Legislation World Health Organisation, Geneva, quarterly, analysed from 1970.
Roemer R. *Legislative Action to combat the world smoking epidemic*. World Health Organisation, Geneva. 1982

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Source: https://www.industrydocuments.ucsf.edu/docs/zphl0000

PERSONS WHO MADE SUBMISSIONS TO THE TOXIC SUBSTANCES BOARD OR ITS TOBACCO SUBCOMMITTEE ON TOBACCO PROMOTION

ORAL SUBMISSIONS

Professor Robert Beaglehole, Department of Community Health, School of Medicine, University of Auckland, oral and written submissions on the epidemiology of tobacco use and disease.

Dr Sharon Boyse, Senior Scientific Adviser, British American Tobacco, London, on the epidemiology of diseases.

Mr Randal Dobbs, Association of Accredited Advertising Agencies of NZ Inc (AAAANZ), on tobacco advertising.

Mr Graham Elie, Marketing Director, WD & HO Wills (NZ) Ltd, on tobacco marketing.

Professor Frederick Fastier, Emeritus Professor of Pharmacology, University of Otago, oral and written submissions, on addiction.

Mr David Forsythe, Executive Director, Association of NZ Advertisers, oral and written submissions, for a tobacco advertisers viewpoint.

Professor Stanton Glantz, Department of Medicine, School of Medicine, University of California, San Francisco, on tobacco advertising in relation to public health policy.

Dr Alan Gray, Medical Director, Cancer Society of New Zealand, on cancer due to tobacco use.

Mr Patrick Greene, Executive Director, Newspaper Publishers Association of New Zealand, for a newspapers viewpoint.

Mr James Haggerty, General Manager, Global Sports and Promotion Ltd, oral and written submissions, on sports promotion.

Mr Selwyn Henshaw, AAAANZ, on tobacco advertising.

Mr Lewis Herbert, Action on Smoking and Health, for an anti-smoking viewpoint.

Mr Peter Hoobin, General Manager, Mercury Theatre, on cultural promotion.

Mr Chris Ineson, Executive Director, AAAANZ, oral and written submissions, on tobacco advertising.

Mr Chris Meads, Economist, Wellington, on his research into advertising effects on sales.

Dr Philip A Silva, Medical Research Council Career Fellow, and Director, Dunedin Multidisciplinary Health and Development Research Unit, Department of Paediatrics and Child Health, Medical School, University of Otago, Dunedin, on the commencement of tobacco smoking in young people.

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Mr John Shuttleworth, Programme Manager, Sports, Hillary Commission for Recreation and Sport, *on sponsorship.*

Mr Glen Smith, Chairman, Children's Research Unit, London, oral and written submissions, on the commencement of tobacco smoking in young people.

Mr Michael Thompson, Executive Director, Tobacco Institute of New Zealand, oral and extensive written submissions, on tobacco and tobacco promotion.

Mr Paul Viner, Managing Director, WD & HO Wills (NZ) Ltd, for a tobacco manufacturing viewpoint.

Professor David M Warburton, Department of Psychology, Reading University, Reading, oral and written submissions on addiction.

Mr Ray Weekes, Chief Executive, Rothmans of Pall Mall (NZ) Ltd, for a tobacco manufacturing viewpoint.

Mr Ian Wells, Newspaper Publishers Association of NZ, on newspapers and advertising.

WRITTEN SUBMISSIONS

Dr Michael Carr-Gregg, Coalition Against Tobacco Advertising and Promotion, on tobacco imaging.

Ms Deirdre Kent, Director, Action on Smoking and Health, on smoking and health.

Mr Peter Mullins, Sage Consultants, on the causality of disease.

Professor Richard Pollay, Business Administration, University of Vancouver, British Columbia, on history of tobacco advertising.

SUBMISSIONS ON TOBACCO SPONSORSHIP

Mr G M Anderson, Secretary, NZ Amateur Cycling Association (Southland).

Mrs Joyce E Bagnall, Secretary, Waitemata Ladies Golf Club Inc.

Mr David Beatson, Chairman, Committee of Advertising Practice.

Mr D J Brunton, President, Canterbury Provincial Bowling Centre.

Coopers and Lybrand, Secretaries, North Otago Rugby Football Union.

Mr P G Cunningham, Executive Director, NZ Football Association Inc.

Mr M D Chandler, President, National Council of Motorsport.

Mr Joe Desmond, General Manager (past) Mercury Theatre.

Mr G T Dowling, Chief Executive, NZ Cricket Council Inc.

Mr John Eagles, President, Forbury Park Trotting Club Inc.

Mr Alan Fraser, Secretary, Auckland Football Association Inc.

Ms Chris Gatford, Secretary, Canterbury Ladies Kennel Association Inc.

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Mr D J Lamont, Chairman, Otago Football Association.

Mr D J Lloyd, Chief Executive, Canterbury Jockey Club.

Mr Des J Lyons, Executive Director, Outward Bound Trust of New Zealand.

Mr F McWhia, President, Woburn Bowling Club.

Mr G A Mackay, Secretary, NZ Bowling Association.

Mr Peter Macky, Secretary-Manager, Auckland Rugby League Inc.

Mr W J Martin, Managing Director, Rally of NZ Ltd.

Mr Richard Matheson, Secretary, Canterbury Working Dog Association Inc.

Mrs P B Miers, Secretary, Waikato Centre of the NZ Bowling Association.

Mr Lionel Parsloe, President Manukau Tenpin Bowling Club Inc.

Mr J F Patterson, Secretary-Manager, Auckland Trotting Club Inc.

Mr Graham Pearce, General Manager, Auckland Lawn Tennis Association.

Mr S J Penny, Secretary, Avondale Jockey Club.

Mr S Richardson, Secretary, Wellington Harness Racing Club Inc.

Mr A J Smithard, Chief Executive Officer, Motor-sport Association of New Zealand Inc.

Mr W J Taylor, President, South Canterbury Cricket Association.

Miss Judith Thomas, Secretary, NZ Horse Society Inc (Canterbury).

Mr John Voyle, Executive Officer, NZ Softball Association Inc.

Mr D T Westrupp, Secretary, Eagles Golfing Society of NZ.

Mr Mark Young, Manager, Tenpin Bowling, Tauranga.

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Econometrics: A branch of statistics used to sort out the effect of simultaneous competing influences. Multiple regression is used to hold other influences constant, while the influence of one factor can be measured. Usually 20 to 100+ observations are needed.

Tobacco Institute of New Zealand: A public relations group representing the interests of the tobacco manufacturers.

Tobacco Manufacturers: The Continental Cigar Company, Rothmans of Pall Mall (NZ) Ltd and WD and HO Wills (NZ) Ltd.

Tobacco Products: These include cigarettes, cigars and cigarillos and loose tobacco.

Loose Tobacco or 'other manufactured tobacco' is pipe or handrolled (roll-your-own) tobacco.

Cigarettes are in New Zealand only counted by number, ('sticks' or 'pieces'), whereas some countries count in tonnes 1 tonne = 1 million cigarettes. After subtracting weight of filter and paper, actual tobacco in New Zealand cigarette weighed 0.8 to 0.85 grams in 1988.

Toxic Substances Board advises the Minister of health on necessary changes in the Toxic Substances Act 1979 for the control of poisons and other toxic substances, including tobacco.

Smokers:

Cigarette smoker	includes smokers of manufactured and handrolled cigarettes -
A regular smoker	is either an occasional or daily smoker
A daily smoker	smokes at least once per day
An occasional smoker	has smoked in the last month, but not daily
Never smokers	have never smoked regularly
Ever smokers	current smokers plus ex-smokers
Percentage Uptake	percentage of eversmokers in the population
Percentage Quitting	percentage of ever smokers who no longer smoke

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